THE HOSPITAL ALMONER

A Brief Study of Hospital Social Service in Great Britain

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PUBLISHED BY A COMMITTEE OF THE
HOSPITAL ALMONERS' ASSOCIATION

TAVISTOCK HOUSE (NORTH),
TAVISTOCK SQUARE, W.C.1.

TO THE MEMORY OF

CHARLES STEWART LOCH,

LL.D., D.C.L.

1849-1923.

IT is not as the great exponent of organized charity, nor as the teacher of the value of personal service and "friendly love" that we Hospital Almoners chiefly think of Sir Charles Loch, but as the founder of the particular branch of social service that we are appointed to carry on. For the work of the almoners was, as he once wrote, the "child of his own thoughts," the outcome of a very intimate study that he made into the workings of the out-patient departments of the London hospitals, and so closely did he ally himself with the work that in talking or writing to almoners he always used the pronoun "we."

Looking back to the early pioneer days, it seems extraordinary to remember how keenly he entered into the working out of the new experiment. No matter how busy he might be with Royal Commissions, International Sociology, or Charity Organization Society Committees, he always had time to have a talk with a hospital almoner who wanted help or advice, and he had that wonderful gift of the capacity to give himself up to her difficulties for the time being as if she and he were partners in the work, and that work were his special concern. Looking back, too, how clearly those interviews and the man himself stand out, his nice sense of humour, his fearless outlook, his abhorrence of all that was false or sham. All that was paltry or mean in one's outlook just dropped away, it did not come within his ken. "The good will of considerate tact," "unity of thought and purpose," "the judgment that is unbiassed, impartial and impersonal,"

these were the terms in which he dealt. His canvas was a large one. One went in to consult him about some small question and in a flash he had transferred it to a much bigger issue at such an immeasurable distance from the immediate question that it was possible to leave him feeling that the actual difficulty was by no means solved, and often days might elapse before one grasped that the larger view embraced the smaller. But never did one leave him without feeling inspired by some of his enthusiasm and faith. His demands were seemingly hard. "I can't" was an impossible reply, and the only comfort in facing them was a certain sense of pride in his confidence and friendship. Whatever success the movement for social service and investigation has attained in hospitals is largely due to his inspiration and help in its initial stages, and one likes to think that, in spite of the fact that many of his ideas and ideals have yet to be realized, Sir Charles Loch would be willing for his memory to be associated with the work which he created, and that we may still think of him as "one of us."

A. E. C.

CONTENTS.

PAGE

FOREWORD vii

CHAPTER I.

THE DEVELOPMENT OF THE BRITISH HOSPITAL SYSTEM 1

CHAPTER II.

THE EARLY DAYS OF ALMONERS' WORK 14

CHAPTER III.

ALMONERS' WORK TO-DAY 20

CHAPTER IV.

CERTAIN ASPECTS OF ALMONERS' WORK 47

1. IN A CLINIC FOR THE TREATMENT OF VENEREAL DISEASE 47
2. IN A CHEST HOSPITAL 54
3. IN A MATERNITY DEPARTMENT 57
4. IN AN OPHTHALMIC HOSPITAL 63

CHAPTER V.

A DAY IN AN ALMONER'S OFFICE 69

ADDENDA. A. STATE AID FOR SPECIAL WORK IN VOLUNTARY HOSPITALS 75

B. CONTRIBUTORY SCHEMES 76

C. APPROVED SOCIETIES 76

FOREWORD.

LAST summer, the British National Committee for the Second International Conference on Social Work asked the Hospital Almoners' Association to prepare a memorandum on almoners' work for the use of the various study circles throughout the country, and also to provide a list of existing publications and literature for use at the Frankfurt Conference. A small sub-committee of the Association was formed and the memorandum was written and presented. But where was the literature? Beyond the annual reports of the Almoners' Departments in different hospitals, many of which were full of interest and information, but all of which were written for the authorities of individual hospitals, practically no literature existed. Perhaps it is characteristic of British mentality that, while for over thirty years the almoners have been at work striving to link up in a common effort doctor, nurse, patient, with the patient's home, family, and the social workers beyond the hospital gates, yet no handbook, no publication has ever been compiled to record the results of those efforts, no history of the Almoner Movement has been written, nor has there been any attempt to collect the various interpretations of the work in specialized hospitals. In fact, the almoner had no literature to offer to the public either in England or beyond its shores.

The Hospital Almoners' Association resolved that an attempt must be made to remedy this defect, and in the autumn this sub-committee met again and decided to issue a series of pamphlets. Various almoners were asked to contribute papers on different aspects of the work. That work differs to some extent in every hospital, for like human beings no two hospitals are the same, each has its own characteristics, individual traits and background. And if this is so in the case

of hospitals in one small country, how true it is of the different forms of Hospital Social Service that have sprung up all over the world. The work is moulded by the frame in which it is set, hence it seemed necessary in this book to give as preface some account of the historical development of the British Hospital System in that it throws light on much of the detail of the English almoner's work. The pamphlets provided material of interest and value, but of necessity there was some reduplication, while shortage of time has made it impossible to cover every aspect of the work. Thus, in its present form, this book has no single author, it is the recorded experience of a widely scattered number of almoners, set down on paper in moments of leisure. It is hoped that the pieces make a pattern which may convey to the reader some idea of the possibilities and existing field of action of almoners' work.

CHAPTER I.

THE BRITISH HOSPITAL SYSTEM AS IT EXISTS TO-DAY.

THE British Hospital System as it exists to-day includes both voluntary and municipal hospitals and, in addition, a large number of clinics founded within the last few years for special purposes.

Voluntary Hospitals.

The Voluntary Hospitals are of a very varied origin which can only be made clear by a short historical retrospect, taking us back to the earliest recorded history of these islands.

The first hospitals were probably Druidic, and we are told that the "Brion Beargh" or "House of Sorrow" was founded in Ulster by Princess Macha "of the golden hair" in 300 B.C. It formed part of the royal residence, though separated from it, and was devoted entirely to the care and cure of the sick. During the Roman occupation Valetudinaria, similar to those in Italy, were no doubt established, but these would only be for the army and civil administrators and not for the sick poor of the country. The Christian spirit which led men to care for the poor and sick was introduced by St. Augustine in 596 A.D., but this spirit cared for their souls rather than their bodies, striving to bring them to repent of the sins which were supposed to have brought the sickness on them, and this was the attitude which prevailed throughout the Middle Ages. The Greek spirit of scientific medicine was entirely lost. In fact, the members of the religious orders which owned the hospitals were positively forbidden to study anatomy, while rich men founded "Bede" Houses (Old English "biddan" = to pray) in order that the inmates might pray for the souls of the founders. The only hospitals where the personal sinfulness of the patients was not stressed before everything else were the Leper Houses which were established with the primary object of separating these sufferers from their fellows, and perhaps exhibited a first dim groping after hygiene.

The first Saxon hospital to which there is actual reference

was founded at St. Albans in 794. We also hear of a Saxon hospital at York in 937, and of St. Giles at Beverley and St. Nicholas at Pontefract.

The Norman Kings took great interest in the building of hospitals. Henry I founded St. Bartholomew at Oxford and Stephen rebuilt St. Peter's at York, at his own expense, after it had been destroyed by fire. These hospitals, however, no longer exist. The oldest building which has come down to us is St. Cross at Winchester, but this has become an Almshouse; a fate which has also befallen St. Mary's, Chichester; St. Giles, Norwich; and St. Nicholas, Salisbury. In 1123 Rahere, prior of St. Bartholomew in London, founded the hospital of that name on the site in Smithfield where it still stands, and this is probably the oldest hospital with an unbroken record of the care of the sick. The origin of the other great mediæval general hospital in London, St. Thomas's, is more obscure. It may go back to the ninth century when St. Swithin, Bishop of Winchester, converted a small convent standing on the southern bank of the Thames into a College of Priests and in 1006 this became the Priory of St. Marie Overie, where the sick and maimed were cared for. In 1080 the Priory of Bermondsey was built close by, but the whole of Southwark was destroyed by a great fire in 1207 and both buildings disappeared. Peter de Rupibus, Bishop of Winchester, decided, however, to unite these two foundations into one, dedicated to Thomas à Becket, and, in 1228, the direct forerunner of the present St. Thomas's Hospital was founded on the site where it stood till 1871. "An ancient Hospital built of old to entertain the Poor." One other London hospital traces its existence back to Plantagenet times. This is the Bethlehem Hospital, founded, in 1246, as a priory to receive the Bishop of Bethlehem if he should come to London. How it first came to be used for the insane—as a place of confinement—is not known, but the first mention of its being so used is in 1403.

Throughout the Middle Ages, the hospitals remained under monastic rule, but as the old spirit degenerated corruptions crept in. Kings used to lodge in the hospitals when travelling about the country and sent their old retainers to end their days in them, and thus the sick were crowded out. The monks, too, spent the revenues in purchasing relics of saints to attract the pious instead of using the money for those for whom the hospitals were originally intended. And so it came to pass that at the Reformation the hospitals were found to be as corrupt as the monasteries on which they depended, and Henry VIII suppressed both alike, leaving England almost

without hospitals. Only those which were attached to the cathedrals and governed by their clergy, such as the hospitals at Bath and Norwich and St. Cross at Winchester, remained. With the Reformation, however, came the Renaissance and the revival of scientific medicine. This Henry VIII encouraged, and his reign saw the foundation of the Royal College of Physicians by Linacre, in 1518, and the appointment of Regius Professors of Medicine at Oxford and Cambridge in 1540. None the less the hardships inflicted on the sick poor were very great and the citizens of London raised an outcry against the suppression of their ancient hospitals of St. Bartholomew and St. Thomas. In 1538 they presented a petition to the King asking him to hand these back to them and promising so to conduct them that they would not encourage vagrancy. Finally Sir Richard Gresham, Lord Mayor of London, persuaded Henry VIII to use the confiscated property of some of the religious orders to found five new Royal Hospitals. Actually only St. Bartholomew's was re-founded in his lifetime and he left his successor to carry out the rest of his plan. Edward VI, however, altered the scheme and, while Bethlehem Hospital continued to receive the insane, Bridewell, built in 1522, was turned by him into a "house of correction," and Christ's Hospital into a school for destitute and fatherless children, so that St. Bartholomew's and St. Thomas's (re-founded 1552) were the only hospitals in London treating the sick poor until the eighteenth century.

During the next two centuries though many almshouses were founded hardly any hospitals were built. It was not until the eighteenth century that the terrible state of the sick in the country raised public opinion to any extent. The Elizabethan Poor Law was intended to relieve the needy and set them to work rather than to care for the sick, and the old hospitals had almost all disappeared or been put to other uses, so that the sick remained neglected in their own homes or in the streets. The early years of the century saw the founding of Guy's Hospital which, being endowed, belonged to the old rather than to the new dispensation. In 1704 Thomas Guy, a bookseller and publisher in the City of London, was elected a governor of St. Thomas's and on his death he left his fortune of £200,124 2s. 7½d., made in the South Sea Bubble, to found and endow a new hospital. This bequest was carried out in 1724 and Guy's was opened in close co-operation with St. Thomas's, originally as a hospital for incurables who were denied admission to either of the general hospitals, but the rivalry between the two institutions was very keen and eventually the two medical schools were

separated. Even before Thomas Guy, Dr. John Addenbrooke of Cambridge had left his fortune in reversion to found the hospital which still bears his name in that town.

The same spirit was working in Scotland. The Royal College of Physicians was founded in Edinburgh in 1683 by Scottish graduates from Leyden University, where Scottish doctors had been wont to take their medical course and in 1726 the Medical Faculty of Edinburgh University was created. In 1725 the physicians suggested that a hospital should be established and called a meeting together to raise funds. As a result certain subscribers bound themselves by a voluntary bond to give £5 each, provided that £2,000 was collected by a certain date. The sum was duly collected and Managers were elected in December, 1728. In January, 1729, a small house with six beds in Robertson's Close at an annual rental of £50 was taken as a hospital. This, the origin of the Edinburgh Royal Infirmary, was opened to patients in the following August. The physicians gave their services and patients were to be admitted free from all parts of Scotland. In 1736 the surgeons built a hospital of their own in the College Wynd and after some vicissitudes these two ventures were finally amalgamated in a new building in Infirmary Street completed in 1747 or 1748. A similar institution was opened in Aberdeen in 1741, while the Royal Infirmary at Glasgow, famous for the fact that Lister was a surgeon there from 1861 to 1869, was founded in 1792.

The Royal Hospitals had all been endowed, and in them the medical staff received a salary and the patients had to make some payment or present a governor's letter. We are told that at St. Bartholomew's each patient had either to bring a governor's letter or deposit 19s. 6d. as a burial fee. The result of this rule was that many of the poorest were unable to gain admission and died outside. So great did this scandal become that in 1828 St. Bartholomew's opened a small dispensary in Hatton Garden to admit the poor without payment. This dispensary eventually became the Royal Free Hospital.

The Voluntary Hospital movement proper had, however, started a century earlier. In 1720 the Westminster Infirmary (now the Westminster Hospital) was founded in London, being the first hospital without endowments and dependent solely on voluntary subscriptions. It also established the principle that the services of the medical staff should be unpaid and that the patients should be treated free. Out of the Westminster Hospital, as the result of a quarrel, grew St. George's Hospital. Some of the governors con-

sidered that the site of the Westminster, situated between the then unbounded Thames and a marsh, now St. James's Park, was unhealthy and, seceding, founded another hospital at Lanesborough House on higher ground near Hyde Park, which was used till the present building of St. George's was erected in 1823-1833. The London Hospital was started by a little group of men who met at the Feathers Tavern, in 1740, under the leadership of John Harrison, a surgeon, and planned the original enterprise. Here the subscriber was given a voice, not only in the selection of the patient but in the management of the Hospital, and these early gatherings of subscribers may be taken as the forerunners of the House Committees which manage modern hospitals. Next came the Middlesex Hospital, founded in 1745, and upon the establishment of the London University in Gower Street early in the nineteenth century it supplied, through its offshoot, the North London Dispensary in George Street, Euston Square, opened about 1828, the practical instruction for medical students. The rapidly increasing number of students, as well as patients, in this poor part of London, showed the demand for a properly equipped hospital, and in 1833 the dispensary was merged in the North London or University College Hospital. In the provinces, Winchester founded a hospital in 1736, on the model of the Westminister Infirmary, followed by Bristol and York. The Birmingham General Hospital was projected in 1735, but owing to financial difficulties building was delayed for some years and the hospital was not opened till 1779, when it contained forty beds. The Leeds General Infirmary was founded in 1767 by a committee under Mr. W. Hey and the Radcliffe Infirmary, Oxford, by Dr. John Radcliffe in 1770.

While the eighteenth century witnessed the rise of the voluntary general hospital, it is to the nineteenth that the special hospital owes its birth, and the moving force behind is a different one. The great reproach that the sick were left untended had been removed, and the new movement was scientific rather than humanitarian in origin, and came from the medical profession who wanted to get better opportunities for the study of certain diseases. Thus in 1804 Dr. Cunningham Saunders founded the London Dispensary for the relief of the poor affected with "eye disease," and this was the origin of the Royal London Ophthalmic Hospital, Moorfields. This was followed in 1816 by the Royal Westminster Ophthalmic Hospital, founded by George James Guthrie, who had noticed soldiers suffering from ophthalmia after their campaigns in the East. Specialization in the study of tuberculosis had begun even earlier, the Royal Sea Bathing

Hospital at Margate being founded in 1791, while in 1814 Dr. Isaac Buxton founded the first hospital in Europe for the study and treatment of consumption, namely the London Royal Hospital for Diseases of the Chest, and the Brompton Hospital followed in 1846. Queen Charlotte's Maternity Hospital received its present name when it was moved to Marylebone in 1809, but its forerunner was a house with twenty-five beds opened by Sir Richard Manningham in Jermyn Street in 1739. Other special hospitals followed quickly. St. Mark's Hospital for Fistula was founded by Dr. Frederick Salmon in 1835, the Royal Orthopædic Hospital by Dr. W. J. Little, and the Metropolitan Ear, Nose and Throat Hospital by Dr. James Yearsley, both in 1838. In 1842 Dr. Protheroe Smith, lecturer in midwifery at St. Bartholomew's, founded the Samaritan Free Hospital for Women, and in 1851 Dr. William Marsden the Cancer Hospital in Fulham Road, though a special cancer ward had existed in the Middlesex Hospital since 1792. The Hospital for Sick Children, Great Ormond Street, was founded by Dr. Charles West in 1852, and the Royal Dental Hospital in 1858. The same year the Royal Mineral Water Hospital at Buxton was founded through the generosity of the Duke of Devonshire, and between 1860 and 1870 some thirty special hospitals were established throughout England.

The hospital treatment of the insane and of those suffering from infectious diseases must be mentioned here as far as the earlier history is concerned, but the later history belongs to that of the Municipal Hospitals. In the Middle Ages the insane were regarded as being possessed with devils and when they were placed in an institution, such as the Bethlehem Hospital, it was in no wise for their own benefit, but simply in order to protect the general public. They were often very cruelly treated and were chained in dark cellars, half-starved and kept in a filthy condition. The public conscience felt no pang at this treatment, and it was a fashionable amusement to visit and laugh at the inmates of Bethlehem, a penny being charged for admission.

The beginning of a movement towards better things came about in this manner. In 1792 a patient in York County Asylum became very ill and died shortly after admission. The relatives, who were Quakers, were not allowed to see her, and feeling that the circumstances were suspicious, they went to one of their community, a certain William Tuke, a tea merchant in York, and put their case to him. The following year he appealed to his friends to try and establish a "retreat" where the insane could be treated by quiet methods. He got very little support at first and was even opposed by

his wife, but he won over Lindley Murray, the grammarian, to his side and, with the help of his son Henry and his grandson Samuel he persuaded the Quakers of York to agree to the founding of a "retired habitation." It was first opened in 1796 and attained fame by the modernity and gentleness of its methods. William Tuke remained at the head of it till he died in 1823, at the age of 90, and was succeeded by his grandson Samuel, who carried on the work for another seven years. The Retreat was originally intended only for Friends, but now members of other denominations are admitted. The Superintendent was, however, always a Friend until a few years ago. The Retreat still exists and is one of the thirteen registered (i.e., private) mental hospitals in England. It is perhaps curious to note that William Tuke's venture in York was contemporaneous with a similar movement for the more humane treatment of the insane instigated in France by Philippe Pinel. This marks the first epoch in the public attitude to the insane, the epoch of humane treatment. The second epoch, that of non-restraint, had its beginning in 1830-1840, with Dr. Gardiner-Hill of Lincoln. In 1851, Colney Hatch was built and was the first large hospital to use scientific methods of treatment as opposed to the mere confinement of the insane. From then on progress was rapid and many mental hospitals were built by local authorities. The third epoch, that of hospitalization, began in Scotland in 1890-1900, with Sir Thomas Clouston and Dr. Yellowlees and has gradually spread south to England.

The only infectious persons segregated in the Middle Ages were the lepers, but it so happened that about the time when the incidence of leprosy declined that of syphilis increased, and the sufferers from that disease, excluded from the general hospitals on religious grounds, were gradually accommodated, though not treated, in the old Lazar Houses. The first hospital intended specifically for the treatment of venereal disease was the London Lock Hospital, opened in 1746, and, in spite of much opposition, the movement spread throughout the country and other Lock Hospitals were opened. Fevers were not treated in special hospitals till the second half of the eighteenth century, an exception being the Middlesex County Hospital for Smallpox, founded in 1746. A pioneer in the cause of isolation, however, was Dr. Richard Mead, Physician to St. Thomas's Hospital, who was asked, when England was threatened with plague in the second decade of the eighteenth century, to advise precautionary measures, and in 1720 he published his "Short Discourse concerning Pestilential Contagion," in which he condemned the practice

of shutting up an infected house with its sound and sick inmates together for a month as both futile and cruel. He counselled instead that when the disease appeared in a town a Council of Health should be formed, charged with the duty of removing the sick to a spot three or four miles outside the town boundaries and of cleansing and removing those who had been in contact with them. In 1783 Dr. Heygarth founded a Fever Hospital in Chester and other large provincial areas soon followed suit. There was, however, considerable opposition to the treatment of fevers in special hospitals, it being thought, in a time when antiseptic precautions were unknown, that the herding together of the patients would favour the spread of the disease. In spite of this, the movement grew and the London Fever Hospital was founded in 1802 and still exists as a private fever hospital for paying patients of moderate means. Such was the position till 1875 when the Public Health Act made it the duty of the public authorities to make provision for fever cases.

Two other new ventures are of interest. One was the opening of the Royal Hospital for Incurables, Putney Heath, incurables having been debarred from the general hospitals. The founder was Dr. Andrew Reed, a friend of Charles Dickens, who started his enterprise with a Mansion House Fund in 1854. The other in 1859 was the first Cottage Hospital founded by Mr. Albert Napper, F.R.C.S., at Cranleigh in Surrey. Up to this time all cases of illness or accident arising in the country towns or villages were either sent to the nearest county hospital or else treated at home. The success of this enterprise may be illustrated by the fact that there are now more than 800 cottage hospitals in the United Kingdom.

All these voluntary hospitals were separate entities, largely a law unto themselves, and all competing against each other for funds. This position continued unchecked till the end of the last century, when a movement began to co-ordinate the work of the voluntary hospitals in London where the effects of their individualism were most marked. In 1897 the fund now known as King Edward's Hospital Fund for London, was inaugurated, under the presidency of the Prince of Wales, later King Edward VII, to commemorate the sixtieth anniversary of the accession of Queen Victoria and to "secure more efficient support for the hospitals of London." This Fund makes annual grants to all the voluntary hospitals of London. In addition, any building schemes are sent up to the committee for approval and, if approved, an extra grant is made towards their cost. At the same time it has instituted

certain reforms in the organization of the hospitals, particularly by the introduction of a uniform method of keeping accounts.

Municipal Hospitals.

The Municipal Hospitals, that is those maintained by the rates, belonged to the local Boards of Guardians and were administered under the Poor Law till 1930. For centuries the Poor Law authorities, who came into existence in the reign of Queen Elizabeth, made no provision for institutional treatment of the sick. The report of the Poor Law Commission of 1832-34 hardly mentions the sick poor, only assuming that they shall receive outdoor relief, and from 1834 to 1847 no orders were made which changed the existing practice by which the sick poor were treated in their own homes. The General Consolidated Order of 1847 insisted that the inhabitants of workhouses should be segregated in seven separate classes, but the " sick " were not one of those classes. From 1847 to 1871 the central authority was the Poor Law Board; but, though occasional reference is made to the sick wards of workhouses, no provision for the institutional treatment of the sick was made till 1865 when, as a result of a public outcry against existing conditions, an order was made and statutory powers were obtained by groups of Boards of Guardians in the Metropolis for the provision of hospitals. The existence of the separate Poor Law Infirmary may be dated from this time and henceforward the policy of the central authority was directed towards obtaining better accommodation for the sick poor from backward Boards of Guardians.

In 1871, the Local Government Board became the central authority and supported institutional treatment on grounds of medical efficiency. It even sanctioned the establishment of special hospitals for certain classes of patient; e.g., the tuberculous, the epileptic and the feeble-minded. The Poor Law Commission of 1905-1909 found that the medical evidence was overwhelmingly in favour of inducing the sick to seek early treatment in the Poor Law Infirmaries and of removing the stigma of pauperism which meant the loss to a man of his parliamentary and municipal vote and thereby acted as a deterrent. (This disqualification was not removed till the Representation of the People Act of 1918 was passed.) The same Commission appointed a distinguished Scottish officer, Dr. McVail, to inquire into the methods of indoor and outdoor Poor Law Medical Relief and he found an astonishing diversity in different areas. Some of the Boards of Guardians

were still trying to deter people from seeking medical relief, and in all cases application had to be made through the Relieving Officer. He found that while in London and some of the largest towns there were separate infirmaries which were but little inferior to the voluntary hospitals, in rural districts, at the other extreme, there were sick wards of workhouses where accommodation and nursing were totally inadequate. His advice was that Medical Relief should be removed from the Poor Law and handed over to a public health service. No Act of Parliament was passed as a result of the findings of the Commission. In 1913, a Poor Law Institutions Order was made by which the Guardians were to make "skilled nursing attendance available for the inmates of every institution."

In 1929 the Local Government Act which came into force on April 1, 1930, was passed. This Act abolished the Poor Law and transferred all the duties and property of the Boards of Guardians to the local County and County Borough Councils which were to appoint Public Assistance and Public Health Committees to do the necessary work. By this Act the old Poor Law Infirmaries became Municipal Hospitals.

In addition to maintaining these general hospitals, the County and County Borough Councils are also responsible for the care of the insane and of fever cases, but the recognition of this responsibility and the making of statutory provision for carrying it out are a comparatively modern development.

The earlier history of the treatment of the insane has been recorded under the section dealing with voluntary hospitals, and it was not till 1774 that any provision was made for the public supervision of private asylums. The first of the present County and County Borough Hospitals to be opened was that for the County of Norfolk (Thorpe, Norwich), in 1814. Between 1848 and 1871 the Lunacy Commissioners, instituted in 1828 by Act of Parliament, were obliging each county authority to provide for the treatment and cure of the insane regardless of cost, this cost being borne by the local Poor Rate. This policy was opposed by the Poor Law Authorities, who regarded it as wildly extravagant and continued themselves to grant out relief to the insane without incurring the displeasure of the Poor Law Board, a chaotic situation which was only reduced to order and uniformity when the two authorities came under the Local Government Board in 1871. The third epoch in the treatment of the insane, that of hospitalization, has borne fruit in the passing of the Mental Treatment Act of 1931. This Act allows for the admission of "voluntary boarders" to public mental

hospitals and even for the treatment of non-volitional patients for a limited time, not exceeding one year, without certification. Some years before the passing of the Mental Treatment Act, however, namely in 1923, the London County Council opened the Maudsley Hospital with money left for the purpose by Dr. Maudsley, and this hospital is intended solely for the in-patient treatment of early mental cases. No certified patients are taken.

The State did not oblige the public authorities to make provision for fever patients till the passing of the Public Health Act of 1875, and the first provision made was of a miserable and makeshift character. When epidemics occurred, the sick were segregated in temporary huts or tents or in old battleships moored at the mouths of the Thames and other rivers. The provision of well-equipped, up-to-date hospitals belongs to quite modern times.

The assumption of the responsibility by the State for the treatment of venereal disease dates from the passing of the Venereal Diseases Act of 1916. Owing to the policy voiced in the Act no special hospitals were opened, but grants were made to establish clinics in the existing general and certain special hospitals, such as skin hospitals. This policy aims at encouraging sufferers to seek early treatment. With this object in view very strict regulations with regard to secrecy have been made, and these regulations would obviously have been defeated by the establishment of special hospitals for the treatment of venereal diseases only. With the same object in view, no law has been made for compulsory notification, it being thought that such a law would lead many sufferers to conceal the existence of the disease or to have resort to quacks.

The passing of the Local Government Act of 1929 is bound to have a great influence on the hospital system of the country, but the system involved is so vast compared with the brief two years that the Act has been in operation, that it is impossible to prophesy what may happen. It is interesting to note that, even before the passing of the Act, some of the voluntary hospitals of London had arrangements with the local municipal hospitals by which the voluntary hospitals lent consultants to the municipal hospitals when required, and also had access to the clinical material in the latter for teaching their students; but whether this method of co-operation will be further developed it is too early to say.

We may also mention that as the voluntary hospitals were the pioneers in the treatment of the sick, they were likewise the pioneers in the development of medical social service, and

for the first thirty years after the initiation of this service at the Royal Free Hospital, in 1895, all the almoners appointed were working in voluntary hospitals. In the last few years, however, a very small number of public authorities have made the experiment of appointing almoners trained by the Institute of Hospital Almoners to work in their municipal hospitals. The result of this experiment cannot yet be seen, but as far as it goes it has been successful.

Special Clinics.

In addition to the voluntary and municipal hospitals, a number of special clinics have been started in recent years to treat certain diseases. The chief among these are :—

The Orthopædic Clinic of the Kensington Division of the British Red Cross Society, opened in 1922, in the building where a similar clinic had previously existed for War Pensioners and had been organized by the Kensington Division, but approved and financed by the Ministry of Pensions. The present Clinic exists primarily for the benefit of the professional and semi-professional classes, whose payments cover about four-fifths of the cost of the Clinic, the remaining fifth being raised by the Division from subscriptions, &c. In addition, a large number of insured persons who are at work are treated at the evening clinics, a minimum fee of half a crown per treatment being charged. Certain of the Approved Societies make grants towards the cost of this special part of the work.

Orthopædic Clinics organized by the Central Council for the Care of Cripples. The ideal of this Council is to cover the whole country with orthopædic "posts" grouped round central orthopædic hospitals. The scheme has only come into existence since the War as a result of the great increase of knowledge of orthopædic surgery acquired during the War, but the germ of it may be said to have come from the work of Sir Robert Jones at the Shropshire Orthopædic Hospital at Baschurch, opened in 1900. There are now eight schemes with central orthopædic hospitals throughout the country, in addition to those in the Home Counties which take the orthopædic departments of one or other of the great London hospitals as their centre. The "posts" are intended to provide routine treatment, massage, &c., to the patients in their own locality, and they are only sent to the central hospital by the visiting medical officer when a consultation, X-ray, an operation, or any treatment which cannot be given at the "post" is required.

The British Red Cross Society Clinic for Rheumatism, in

London, was opened in February, 1930. It was built and equipped by the British Red Cross Society at the instigation of the British Committee on Rheumatism and the Health and Trade organizations of the country. The work at the Clinic includes selection of cases, diagnosis, treatment, post-graduate instruction, follow-up and welfare work, together with research into the causes, prevention and treatment of rheumatism. The Clinic is open from 8.30 a.m. to 9.30 p.m. in order to allow patients who are working to attend before or after office hours. It treats, in the general patients' department alone, over three hundred patients per day and all have their appointments booked to time. No patient is treated without an appointment and the system has worked satisfactorily for over two years. Patients who are insured can, in certain cases, obtain treatment as part of their benefit under the National Health Insurance Act, grants being made to the Clinic from the Approved Societies. Non-insured patients contribute according to their means, but if they are unable to afford a minimum fee of 4s. a visit, treatment can only be allowed if grants can be obtained from charitable sources.

The Tavistock Clinic for Functional Nervous Disorders, now the Institute of Medical Psychology, was opened in London in 1920 to provide consultations and out-patient treatment for patients suffering from early mental disease, and in 1929 an additional house was acquired as a hospital to provide accommodation for fourteen resident patients. The Clinic is financed by voluntary subscriptions and donations and by payments made by the patients themselves. In addition to providing treatment for adults, it has a special department for children.

The London Child Guidance Clinic was established in 1929, as a demonstration clinic for the purpose of making known in England the methods of Child Guidance as practised in the United States of America. It was organized by the Child Guidance Council in conjunction with the Commonwealth Fund of America and, up till now, the Commonwealth Fund has financed both the Child Guidance Council and the Clinic.

Similar clinics have been established or are in process of being established in other large towns, e.g., Birmingham, Liverpool and Glasgow.

Finally, in 1931, the Maudsley Hospital established three consultation clinics, one each in East, North and West London, staffed by their own medical officers. These are for the convenience of patients who cannot easily reach the Hospital which is in a rather remote part of South London.

Grateful acknowledgments are made to "The Romance of the British Voluntary Hospital Movement," by Dr. Delbert Evans and L. G. Redmond Howard.

CHAPTER II.

THE EARLY DAYS OF ALMONERS' WORK.

THE birth of an idea can seldom be dated accurately, but it is certain that as early as 1885 Sir Charles Loch had recognized the need for some kind of social service within the walls of the hospitals. In an address to the Metropolitan Provident Association in that year, he suggested that there was need for a "charitable assessor, or co-operator . . . . well instructed as to all forms of relief other than medical. . . . His office should be to supplement the work of the medical officer by obtaining the general assistance without which medical relief will often fail in its purpose."

The overcrowding of the out-patient departments of the voluntary hospitals was at that time exercising the minds of the authorities. So acute was the problem that a Select Committee of the House of Lords was appointed to investigate the whole question. The report of this Committee, published in 1891, contains much material that must still be of interest to all who are concerned with hospital management. In the section devoted to out-patient treatment the Committee recognized that "an inordinate number of trivial cases wastes the time of the consultee, wearies the attention of the students, and fosters a habit of hasty diagnosis and careless observation, which tends to erroneous and insufficient treatment." It was true that the Governing Boards of the Hospitals had for some time been alive to these evils, and, through various methods such as wage limits, inquiry officers, hospital letters, and introductions from medical practitioners, had to a certain extent limited this misuse of the out-patient department. But Sir Charles Loch, in the evidence which he gave before the House of Lords Committee, proposed as a more effectual method of attacking the trouble, the appointment of Almoners. His proposal is more fully set out in an article entitled "The Confusion of Medical Charities," contributed by him in 1892 to the August number of the *Nineteenth Century*. In this he urged that medical charity could not be isolated from other forms of charity, the same principles must apply to every method of giving. "People talk of medical charity as if it

were a thing apart, unlike all other forms of charity, to be regulated by no principles, to be bettered by no co-operation with others. . . . At the present time what more glaring picture of charitable impotence is there than that destitute persons should constantly apply to a free dispensary for drugs which cannot benefit them if they lack the necessary food; or that in the same illness they should go from one out-patient department, free or even part-pay dispensary, to another without any heed being paid to their actual condition? To be effectual, even to be equitably administered, medical charity must act in alliance with general charity. Their cause is one. Their difficulties are very similar. Each will succeed better with the help of the other."

To the modern mind these may seem platitudes, but at a time when each hospital was still regarded as an isolated unit for the treatment of disease, they were a startling departure from the old trend of thought. The trained social worker within the hospital, whose appointment Sir Charles Loch thus advocated, was intended by him to provide the link between the treatment given in the hospital out-patient department and the realities of the world in which the patient lived.

While Sir Charles Loch recognized that the existing confusion was the symptom of a "new social combination," he believed that "the past unwinds clues for us, if we choose to use them." From the early records of one of London's oldest medical charities, St. Bartholomew's Hospital, he found that the "Almoners," who in later years had become a House Committee, originally had the duty of examining all persons brought to the Hospital and of admitting them at discretion. He saw the possibilities of such an office, reclothed to suit modern needs, and he visualized the future "Almoner" who, trained in methods of sympathetic investigation and scientific relief, should be in a position to introduce organization where now was dislocation and waste.[1]

The article referred to above outlines how this should be done. No matter what difficulties there were to be faced, no matter what obstacles had to be overcome, the whole question of almonership had to be ruled by the fact that medical charity had three aims: The cure or relief of the sickness of the

[1] The title of Almoner has met with many criticisms, yet no satisfactory alternative has been suggested, and despite all objections perhaps Sir Charles Loch showed a subtle understanding of the character and mediæval origin of our English Hospitals when he suggested it. When the office was created at St. Thomas's Hospital the fact that the Executive Board had from its earliest days included six "Almoners" made it necessary to distinguish the new official by prefacing "Lady" before the "Almoner."

poor; the education of the medical and nursing professions; and the scientific study of medicine and surgery. Here then was the basis on which the future work of almoners was to be built. The almoner was to be a *trained* worker, who should possess an intimate knowledge of local charitable institutions; "a man or woman of some insight, prompt decision and firmness." Some patients might require other than hospital treatment, "to them the almoner would attend. Others, because of their poverty, 'not being in circumstances to pay for treatment and physic' (to use the words on the old St. Thomas's out-patient letters) would receive medical attendance at the hospital and might be otherwise helped also. Those who were destitute might be referred to the relieving officer of the district. Persons who could afford to belong to a provident club or dispensary might be referred to one. Some might be told that they should go to a general practitioner. A thoroughly experienced person could form a fairly good judgment on a short examination." If it is surprising that the gifts of tact and sympathy were not added to the list of the necessary qualifications of the almoner, the explanation must surely be that Sir Charles Loch presupposed those qualities in any who would be attracted to this work, for in his training he had always stressed the need for them and for the terribly difficult art of "telling the truth with love."

Sir Charles Loch was at this time Secretary to the Charity Organisation Society, and thus it is that through the years that immediately followed the Report of the House of Lords Committee the history of almoners is closely bound up with the activities of that Society. It was in May 1894 that the Charity Organisation Society, deciding that the time had come for action to follow discussion, instructed its Secretary to approach the Governing Board of the Royal Free Hospital with the offer, as an experiment, of the provision of a trained official who would work along the lines indicated by him. There may have been many reasons why that particular hospital was selected; certainly among them were the following facts. As early as 1875 the Governing Board of the Hospital had for purposes of research permitted a careful inquiry into the circumstances of its out-patients to be made by a branch of the Charity Organisation Society, and had shown much interest in the results. Also, it was a "free" hospital and there was no system of subscribers' letters. In addition to this many members of the Hospital Board, and in particular the Secretary of the Hospital, Mr. Conrad Thies, were in sympathy with the scheme.

After many consultations and conferences the offer of the Charity Organisation Society was accepted, and one winter morning in 1895 Miss Mary Stewart began her work as the first almoner. It seems hardly likely that the shy, somewhat diffident lady, in a small screened-off corner in the out-patient department of the Royal Free Hospital, thought of herself either as part of a movement, or as a possible forerunner in a vast scheme of Hospital Social Service which, in various guises, would gradually develop all over the civilized world. On the contrary, it seems safe to conjecture that as she considered the crowded benches of out-patients her heart somewhat misgave her; that she was filled with dismay at the thought of how she could even attempt to sift and steer them with any measure of success. But service with the Charity Organisation Society had taught her the value of investigation and the power of co-operation. Her duties, as laid down by the Board, were three-fold:—

"(1) To prevent abuse of the Hospital by persons able to pay for medical treatment;
"(2) To refer patients already in receipt of parish relief, and such as are destitute, to the Poor Law Authorities;
"(3) To recommend suitable persons to join Provident Dispensaries."

A somewhat meagre programme in face of the existing need! Fortunately, the memorandum in the Board minutes contained the additional statement that "we have no machinery by which cases of needy and deserving patients can be followed up after treatment. It must frequently happen that a few weeks' change and rest with good food at the sea-side or country would save a valuable life, and there are various Societies willing to help such cases if their attention is drawn to them."

There is no doubt that in the eyes of the hospital authorities the most pressing side of the new work was the prevention of abuse. Speaking many years after of those early days, Miss Stewart emphasized the kindly attitude of the doctors and sisters, who were, however, very vague as to what she might be doing, and were apt to have somewhat strange ideas as to what constituted "abuse." This question had clearly two aspects. In the first place, it was unjust to the medical profession (and also to the hospital's benefactors) for the hospital to accept as patients those who were in a position to pay for the attention they required. Clearly all who could afford to pay fees must be refused the help of the

hospital, and there is no doubt that glaring abuse existed then, to an extent quite unknown to-day. But no hard and fast rules as to family income and rent could be used as a check upon the admission of patients. A clerk who had to keep up a recognized standard in appearance and whose savings had been drained by the continued illness of a child, might well be suitable as a hospital patient, while a labourer, with some minor ailment, who was single, earning a far lower wage, should be dismissed as able to pay for what he needed. Careful inquiry into each case, with verification of the statement of wages, or a confidential inquiry to the family doctor, were some methods employed by the almoner.

The second aspect of the question of abuse, and one which was greatly emphasized in early days, was the pauperizing effect of free medical treatment given unreservedly to all and sundry. The panel doctor has doubtless removed many fears on this score, but in 1896 the hospital authorities were still looking to the Metropolitan Provident Dispensaries as the solution of this evil. The note-books of early almoners contained the addresses of all these, and an almoner's day could not be considered complete until she had forwarded to the right local dispensary lists of all suitable cases that had presented themselves.

But was the almoner to be a free lance to say who should come and who should be dismissed? No indeed. From the start the golden rule was established that all patients were to be seen by the doctor in the first instance, and then by the almoner. The almoner cannot know, unless given a diagnosis, whether a patient's statement of "a cold in the throat" may mean some minor trouble for which his income is sufficient to meet the cost, or may demand a long course of treatment in the Throat Department, or may be an inoperable disease. No patient therefore was dismissed without the consent of the physician or surgeon. In addition to this, hospitals with Medical Schools need certain material, and the needs of the Medical School over-ride, as a rule, any other question.

Such, then, were the principles upon which the work was based. They proved to be a firm and wholesome foundation for growth, and to contain the embryo of unlimited possibilities. During the ten years following Miss Stewart's appointment, seven other Hospital Boards felt justified in starting a similar experiment, not only with the object of checking abuse and misuse of the Hospital, but to watch the development of the new idea of medical aid placed in a true relationship to the general needs of the individual patient.

Though the early almoners had been through various forms of training and had worked in the offices of the Charity Organisation Society, it was felt by 1906 that the time had come when a more systematized scheme of training should be adopted, and in that year Sir Charles Loch formed an *Ad Hoc* Committee, to be known as the Hospital Almoners' Council, with the following functions:—

(1) To draw up a scheme of training for Hospital Almoners.
(2) To select candidates for training and to supervise their studies.
(3) To promote the appointment of competent Almoners.

Those who were already working as almoners had in the meantime (1903) formed the Hospital Almoners' Association, and this body was represented on the Hospital Almoners' Council. The Council continued until 1922, when it became the Institute of Hospital Almoners, Incorporated. The Institute, as the official training body, and the Association, as the corporate body of practising almoners, represent the profession of Trained Almoners in this country to-day.

CHAPTER III.

ALMONERS' WORK TO-DAY.

THE British hospital system exists primarily for the treatment of the sick poor, but also to fulfil several other functions. It turns men and women from the universities into qualified doctors for the benefit of rich and poor alike, and offers them a volume of experience otherwise unobtainable, and the benefit of working under the best brains in the medical profession before they launch out by themselves. In the wards of the hospital the nurses of the nation are trained. They serve the sick, and through the discipline and hardness of their service there, they gain the knowledge and restraint which make them able to stand up to the emergencies of life and death outside the hospital walls. The hospital is a centre for research as well as training. New methods of treatment and equipment are tested in it. Experience is collected and analysed and fresh knowledge is constantly gained.

With all this modern complexity there is one survival from mediæval days. The spirit of service has run through the hospital system for centuries and still plays the same outstanding part in it. It is as much a part of the hospital as the tradition of worship is a part of the beauty of the cathedral.

This is an incalculable asset to the social worker. Unlike doctors and nurses she is a newcomer in the hospital world, but she finds all the benefits of its traditions at her disposal. Whether the almoner is there or not, a tapestry is being woven by the work of the hospital, but it may be an incomplete piece of work and apt to unravel if she does not play her part in gathering up and connecting the broken threads.

Social Work.

It is clear that the measure of an almoner's success will depend to a considerable extent on her power of establishing satisfactory human relationships. To the medical and nursing staff and her fellow-workers she must be a colleague with a contribution which is of value to them in their work, and able to inspire confidence. If she is alone in her department she

may in a sense have a lone hand to play, but has to realize herself as one piece of the complicated machinery of the hospital and has to see her own work in relation to the good of the whole.

To the patients her first duty is that of personal service. The out-patient department of a hospital might be a cross-section of a large part of the world, so varied are the patients attending, and whilst on closer acquaintance their individual characteristics will be revealed, the first casual glance shows rather their typical traits. There sits the wife of a tradesman with her air of conscious independence, her clothes slightly old-fashioned, but well preserved. Her whole appearance reveals years of clean and frugal living, but now there is a strained expression upon her face and about her mouth lines of pain are drawn. On the same seat waits a clerk also respectably and carefully dressed; the slightly deprecating manner which belongs to the man whose employment depends to some extent upon the pleasure of another has become habitual to him. The artisan has made good his claim to independence, he and his fellow-workers have united, and loyally, in good times and bad, they have supported a common aim. He is indifferent to the opinion of the rest of the community, but is slavishly dependent upon that of his own section. A great gulf yawns between the attitudes to life of those who get a regular wage, even if inadequate, and those who are only casually employed and never know what will be the amount of their week's money. On one side a conscious struggle to reach a higher standard is maintained, on the other is acceptance, partly unconscious and partly fatalistic, of the existing conditions. For instance, the woman who is waging a not very successful battle against the gradual deterioration of the family's clothes and household goods, even while she waits to see the doctor may be trying to plan how, from this week's housekeeping money she can buy a new pair of shoes for one of the children. It is no use postponing the problem, next week's wages will be the same, and very soon she will have to get another bed as the children are getting too old to sleep together. On the other hand, although these same difficulties occur in the casual labourer's family they cause far less anxiety, for here is the gambler's hope; perhaps the father will have a good week, then his earnings, which will exceed the regular worker's, will provide some of the much needed replacements. If luck is out and there is no work, state aid will be forthcoming to pay the rent and supply the family's food, whilst voluntary charities may give garments or help with the emergencies which seem to occur perpetually in such homes.

Besides all these, among the waiting crowd there is sure to be some man or woman whose home is a succession of common lodging-houses, and whose means of support are quite invisible. He depends on desultory charity or on an occupation which is hidden from the vigilant policeman. As each of these patients reaches the almoner she must keep their standards in mind and adapt her plans to them.

Some of these patients have attended more or less regularly for months or years, whilst for others to-day is their first visit. The woman with organic heart trouble is reconciled to her lot and has grown accustomed to her family explaining to the sundry visitors to the home that she may do that unlikely thing, "drop dead at any moment." With the same resignation she takes out her knitting and settles down in the out-patient department to a long gossip with her neighbour, their chief topic being symptoms, either their own, or, quite unselfishly, the more interesting and dramatic ones of someone else. Here is the woman who has lived all her life near the hospital and who is so well accustomed to coming to it in every emergency (if she has cut her finger or her child is feverish or the baby has swallowed a halfpenny), that it is a friendly and homely place. There, on the contrary, is the patient who has never before been in a hospital, who is nervous and suspicious, haunted possibly by a terror of illness and needing a sympathetic interpreter of the routine and of the treatment advised. There may be no need of actual help, but great need of allaying the patient's fear and of making him feel at ease in strange surroundings. Amongst all the doctors, nurses and officials who are going about their work so busily there is not one familiar figure, and the patient knows too that when his turn comes he will have to leave his fellow-patients and go through the door alone. He cannot help regarding the doctor with awe, for by curious tappings and listening through a stethoscope more will be discovered about his body in a few minutes than he knows, despite a life-long familiarity with it. Probably he will have to undergo many different examinations and the doctor will with kindness try to allay his nervousness, but, to quote Lord Moynihan, doctors in their official capacity are sometimes either talking "a language which patients are unable to understand or are suggesting actions which they are quite incapable of carrying into effect."

Many of the patients who attend are too ignorant or too poor to benefit from hospital treatment unless there is some co-ordinating authority in hospital to help them; someone to act as guide and director; someone who sees them not as cases of disease, but as men and women stricken for the moment

with illness, yet with a normal life stretching behind and in front, and as members of a family with their own place in the world; someone who can in some way correlate their illness and the circle of difficulties engendered by illness with the possible solution of these difficulties. The ignorant man, dazed by the strangeness and size, and possibly by the technicalities of a hospital, may go away with no clear knowledge of what he is expected to do; the patient going short of food and without the barest necessities of health and life may attend week after week in the out-patient department trusting piteously to the therapeutic value of a bottle of medicine; or worse, a patient having received definite recommendations from a doctor as to treatment may feel that what is advised is a counsel of perfection, so impossible of attainment that the advice seems almost a mockery, if there is no one at hand to help to bring it from the realms of the ideal to the real and the possible.

Very often it is enough for the almoner to explain briefly and simply the reasons for some of the hospital routine. A reminder that all doctors have to gain experience may soothe the nervous woman who has been disconcerted by the presence of a number of students. To point out to a patient who has been prevented by the doctor from pouring out a long and irrelevant story that many more people have to be seen within the limited time, and then to listen, will not only relieve his soreness but perhaps give the almoner a clue to the nature of his social difficulties. They may be very different from what he imagines. Then again it is necessary to make the woman who is in a hurry to return to cook the children's dinner, or the man who hopes to get back to work that afternoon, understand that some delay is inevitable and the different examinations essential if patients are to be properly treated.

The problems which confront an almoner in her work among the patients may be roughly divided under three headings, though the divisions are somewhat arbitrary and each set of problems may overlap and act and react on the others. There are problems of ignorance, problems of poverty and problems of character.

The strength of the almoner's position in hospital is that in the midst of experts she herself is an expert and the purveyor of specialized information. Very often her share in enlightening ignorance may be a trivial matter. It may be the giving of a small definite piece of information to a member of the staff, to a patient, or to somebody outside the hospital, possibly an address—the name of a home or the time of attendance at hospital. On the other hand, it may involve

hours of hard work, the collection of statistics for the medical staff, and information about patients who have ceased to attend which can only be obtained by home visiting and by very detailed inquiry.

The almoner, thanks to her training in social work, thanks to the daily and intensified training which her work gives her, is an authority on social legislation in so far as it touches the lives of the patients—she knows the main resources of the community for the help of those who are in difficulties, the character and workings of various societies and the type of case they are likely to help; she has knowledge of convalescent homes and surgical instrument makers. Besides knowing where to obtain help for patients she knows to what society to apply when she is anxious to obtain a report on home conditions or on a child's record of school work or for information of any sort.

A large number of patients who attend the hospital are in a position to carry out the doctor's instructions provided they clearly understand them and are able to see their significance in terms of their own lives. A patient may be in a position to pay for a period at a convalescent home advised by the doctor, but has not any idea what sort of home he should go to or how he can make the necessary arrangements. Again, a man may be able to pay for an ambulance urgently required to bring his wife up to hospital, but be at a loss to know where he can order one; or able to pay for a surgical instrument for his child, but need instructions where he is to take her to be fitted and the proper procedure to follow. A patient may be and often is entitled to certain additional benefits, of which he has no knowledge, from his Approved Society under the Health Insurance Acts. In problems of greater difficulty which may involve temporary or permanent re-arrangement of life, the patient, overwhelmed by his troubles, is able to turn to the almoner for advice and lay his mind bare, helped not only by her as an individual, but by her as one who represents to him the authority of the hospital, someone who can act both as a guide and as an interpreter.

It is obvious, however, that in a hospital which is serving the poor, and people of small means, the problems which in the main confront the almoner are problems in which finance plays a very large part and where mere advice is not enough. To all classes of society serious illness is a form of earthquake, an upheaval after which, even if there is no fatal disaster, familiar objects appear at a new and sometimes at an alarming angle. With those who are never far from the destitution line, those who, however valiant and self-respecting

their efforts, are unable to put by more than a very little for times of difficulty, the earthquake may swallow them up unless there is someone at hand to help to mitigate disaster.

For a patient who must have prolonged convalescence or sanatorium treatment, or who is suddenly faced by the fact that he will never again be fit for work, material help must somehow and from somewhere be obtained, and must be given in such a way that self-respect and independence are not broken down. Most people learn in course of time, and by bitter experience, that help unwisely bestowed may be utterly demoralizing to the recipient.

Of all the problems which confront the almoner, however, the most difficult are those in which character is a decisive factor. At times the extent to which the services of the hospital can benefit the sick person is in proportion to his ability to accept such services. He may be brought into contact with the most eminent of the medical profession. All the resources of the hospital may be at his disposal—beds, laboratory tests, X-rays, every help to diagnosis and every form of treatment, things that richer men have sold up their homes to get. There is still one essential without which it will be all in vain—his own active co-operation—his power of absorbing and using the advice and treatment he is offered.

There are cases where physical illness is a symptom of some deeper ill: the drug taker, the intemperate drinker, the girl who has broken away from her customary restraint and as a consequence has an illegitimate baby or has been infected with venereal disease; the boy with the "wanderlust" who has left home and is fast losing any power of settling down to support himself by work; the difficult child who is not merely at his most difficult at home, but apparently has the power to rouse all the worst qualities in his parents. In problems like these, unless character, manner of life and general outlook can in some way be changed, efforts against physical ills alone are likely to prove useless.

Unfortunately there is always an irreducible minimum of patients who come to hospital who either cannot or will not change their mode of life, however much their recovery to health may depend on such change. For them medical and social treatment seem equally useless. Time, care, unstinted service are expended on them, but they go away as they came, having taken everything with greedy hands, yet, by the irony from which there is no escape, at a cost to others but with no benefit to themselves. Their problem as a whole is a social rather than a hospital problem and calls for co-operation and research on the part of all social workers. Sooner or later

every branch of social work has to face this apparently unabsorbable element in the community which desires to take everything and give nothing.

The almoner will probably meet the out-patient the first time at the end of a long afternoon of medical examination and tests, and she must be quick to see if the patient is tired and worried, whether the diagnosis has come as a shock, whether to pour out his troubles and discuss matters may be a relief, or whether he is so much at the end of his tether that inquiries must be postponed to another time. To say that the almoner must know the income and the chief items of expenditure of a family, the type of work in which its members are engaged, and later on possibly such salient facts as its religion and amusements, as well as the characteristics of the home, may sound as if lists of questions must be asked and answered. In practice the almoner usually finds that many of these details are volunteered by the patient himself, and it is part of her task to find out the others with the least possible distress to him. In the same way, with in-patients the almoner has to choose the right moment for approaching them in the ward. In most cases she will have made their acquaintance before they were admitted and will know something of their position, but the period while they are in hospital gives her an opportunity of acquiring further knowledge. She learns much by consultation with the sister of the ward, she hears of the patient's actual condition, of his reaction to suffering (an invaluable indication of character and personality), and she must be quick by her own observation to know when the patient would like to talk and when it is wiser to delay any discussion to a later date.

"After-care" of patients is a well-worn phrase, but an almoner's work at its best aims at being something more than after-care, and is more aptly described as "*vorsorge*, *fürsorge*, *nachsorge*," for in many cases help is needed before a patient is admitted to a hospital, while he is an in-patient, and then after he is discharged, until such time as he can regain a normal mode of life and fit into his old place in the economic world, or, if that is impossible. until he has found a new equilibrium and stability. In the same way, where help is needed for an out-patient it is generally while he or she is actually attending the hospital, and medical and social work are thus contemporaneous and act and react on one another. In any case of need other than the trivial, it is important that the almoner should know at any rate something of the patient's normal surroundings and of his home circumstances. In the

days when hospitals were asylums where the sick might remain until they had regained their health, knowledge of the home was not so important in the cure of disease, though at all times essential for its prevention. But in a modern voluntary hospital which is used largely as a consultation centre and where the pressure upon the beds is great, patients are generally discharged as soon as they have passed the acute stage of their illness, and are expected to continue the treatment in their own homes or other institutions, so that the nature of their homes is a matter of vital importance. With the out-patients, just because they are living at home and only attending the hospital at stated intervals, their home is their constant setting and may be the pivot on which the success or failure of treatment depends.

Bad home conditions, financial difficulties, necessity to work too soon, an unhappy mental atmosphere, will all mar and retard a patient's recovery to health and, indeed, may cancel the good gained in hospital. It is for the almoner to strive to give help in such a way that this wastage is reduced to a minimum.

Institutional Treatment.

With patients recommended for admission to the wards the first problems may centre round the actual admission.

The wage earner has to give up his work ; how are his wife and children to manage, for the money from his Health Insurance and his club are not sufficient for them to live on without running into debt? Can the family budget be curtailed without serious consequences—is there any member of the family who can temporarily earn more money—can the wife obtain paid work without neglect of the children? If not, will the relations, friends or employer be able to help until the man is fit to return to work? Failing private help, it is necessary to decide whether the case is one which should apply for assistance from a voluntary society or from the state through the Public Assistance Committee. A letter of explanation of the position and the need, a telephone conversation with the secretary of the Society, will probably be required to simplify the application both for the patient and for the Society.

Again, when the woman is recommended for admission it is possible that she is the bread-winner and then a similar problem occurs. The more usual thing, however, is that she has children of varying ages whom it is most difficult to leave. Often when she first hears the doctor's decision she will feel

that the recommendation to come into hospital is an impossible one, and that whatever the consequences she must stay at home. Sometimes it is enough merely to discuss matters for some plan to emerge. A relation can be summoned to look after the home, a kindly neighbour will take the baby and give an eye to the older children, the husband can have his meals with friends living in the same house or nearby. Sometimes the almoner is called on to make the arrangements herself, to find a suitable home into which the young children can temporarily be admitted or find a foster-mother for the baby either herself or through an outside agency, and probably raise the funds to pay for this. Her aim, in addition to arranging that the children shall be satisfactorily looked after, is to secure as far as possible mental peace for the patient, for worry is a bad bedfellow. In certain instances home difficulties seem so insuperable that after a careful weighing-up of the position the doctor may decide, when he has heard the almoner's report, that it is wiser to postpone admission for a time until it is possible for the patient to come into hospital with a happier mind; on other occasions medical urgency must override everything.

However deeply the almoner believes it to be wrong to interfere fundamentally with the liberty of the individual, there are a few instances of serious illness where the principle has to be laid aside. Perhaps the patient herself realizes that her one hope of life is to accept the proffered bed at hospital without delay, yet cannot decide on what appears to her a selfish course and leave her family in the lurch, while the husband or family refuse to face the gravity of the situation and insist that they cannot cook their own meals or manage alone. The almoner may have to sweep aside difficulties and by the force of her own personality and persuasion almost compel the patient to come into hospital, and certainly compel the relations for once to sacrifice themselves. To overrule rather than convince is, however, a dangerous expedient to be followed only in matters of extreme medical urgency, for it must never be forgotten that the patient's life is his own and is not raw material for other people's good works.

Convalescent Treatment.

As has been stated, many patients are discharged from the wards before they are fit to return to normal life. Sometimes they are recommended for a period of convalescence as a continuation and essential part of the medical treatment, at

other times because the home environment is definitely unsuitable, and because once discharged from the ward continuation of treatment will be impossible. Pushed by economic difficulties the wage-earner may struggle back to work too soon, and in doing so prolong his period of ill-health indefinitely. The mother of a family finds that once she is at home again her promise to supervise and not actually to do her housework is impracticable. The incessant calls made upon her by the other members of the family for advice and instruction, the fact that she must witness the disorganization of her job, added to the improbability of anyone else in the house being able to look after her, force her to resume her tasks far too soon. Often the only way to make certain that she rests and does take the milk and eggs herself instead of giving them to the children is to place her in a convalescent home. She may still carry some of her anxieties with her, but at least she will not have to jump up each time the kettle boils over or someone knocks at the door. She will know for a time the blessings of order and leisure, and have the opportunity with returning strength of making new friends and gaining new interests in life.

So far as such a counsel of perfection is possible, the right home must be chosen for each patient. A home in a sheltered situation and in a mild climate for the patient suffering from chest trouble, a bracing climate for the post-operative case, quiet and peace for the overwrought, brightness and mild gaiety for the patient who needs rousing or who is never happy away from a crowd. Psychological as well as physical needs must be satisfied, and the almoner can never afford to forget that "one man's meat is another man's poison," and that she must find, if possible, a home where the mental atmosphere is likely to be congenial.

Occasionally temperament and medical requirements may conflict, as in the case of a flighty, self-indulgent girl to whom city streets spell happiness and quiet spells boredom, who is suffering from a heart lesion and has been recommended by the doctor for weeks of the placid and uneventful existence which she refuses to lead at home. The success or failure of her treatment will depend in large measure on the wisdom and skill of the matron of the home to which she is sent. To place her satisfactorily is no easy matter, for the demands she makes on patience and on wisdom are very considerable.

There is still great difficulty in finding suitable convalescent accommodation for certain cases—the adult temporarily in plaster of paris, the patient suffering from a disease of the eye where treatment is still needed, the chronic or incurable

case for whom a temporary change of environment is advised, etc.

It is essential that delicate children and those with some organic trouble should be sent to homes where there is adequate nursing and supervision. As a rule, if they are to be in the home for a long period, provision is made for a certain amount of schooling, conditioned to their physical health. This is an important factor both for their present happiness and to prevent them from growing up without proper education.

Children who normally are strong but have had an accident or a minor illness will probably recover speedily at a seaside home with less specialized treatment, provided they have plenty of nourishing food and fresh air. The difficult child, the adult psychological case, will probably need a home where they can have specific guidance and understanding. If home conditions have been contributory causes to bad health it may be necessary, difficult though this may be, to attempt some material or spiritual readjustment of them if the patient is to return home after convalescence without losing much of the good which has been gained.

Instruments and Surgical Appliances.

In most hospitals patients who require instruments or surgical appliances obtain these through the Almoner's Department. The almoner has to convey the surgeon's instructions to the instrument maker, arrange for the patient to be measured, make arrangements for the necessary payment (which will vary from a few shillings to many pounds) and finally see that the instrument, when obtained, is approved by the surgeon.

It may be possible for the patient to pay for the instrument himself. He may be eligible for assistance from his Approved Society under the Health Insurance, or friends or relations or an employer may be willing to help. It may be necessary to approach a charitable agency for assistance. The almoner's responsibility often does not end when the instrument is supplied. With some patients, and especially with children who possibly have to wear a surgical instrument for months and years, it is often necessary to arrange that a visitor shall keep in close touch to see that both parents and child are encouraged in well-doing, that the instrument is worn continuously and that the patient reports at the hospital at due intervals. Without this, in some cases an instrument will

be discarded almost at once, worn irregularly, and worn when the child has grown out of it and when it is definitely harmful.

Special Diet and Extra Nourishment.

In certain diseases such as rickets, nephritis, pernicious anæmia and diabetes special diets are ordered. In others extra nourishment is considered necessary. Such foods constitute a definite part of medical treatment. The diet may not be in itself expensive, but without assistance may be an impossibility for a patient in much straitened circumstances, especially as it often has to be continued for a long period, if not for life. It is for the almoner to organize some practical scheme. Possibly with advice, by consultation with other members of the family, by successful contrivance, the patient will be able to manage and may only need a little help, from time to time, or perhaps occasional exhortation and encouragement on what is as a rule a path of self-denial; others will need definite financial assistance and possibly supervision to see that the doctor's instructions are carried out.

The life of the diabetic child must of necessity be a difficult one, for the régime is strict and temptations are many. The almoner is often able to help the parents, not always materially, but by advice and suggestion and by securing the active and proud co-operation of the child.

Invalid kitchens which are to be found in certain towns are of very great use for the patient who requires special nourishment or specially prepared food which the family is unable to supply.

Rest.

It is often a very difficult problem to arrange rest for the patient who requires it. A rudely healthy family will be sympathetic when one member is acutely ill, but will feel that once he is able to leave his bed he should be fit for normal life. A girl with a tuberculous spine who has lain in a frame for two years is told she may begin to get up and the first day stays up many hours! So little is rest understood. It sometimes happens that after his discharge from the ward a patient has to stay in bed for several weeks. If there is someone at home who can manage the nursing, then he will return there and possibly a district nurse may be asked to visit each day. There are, however, many cases where rest cannot possibly

be arranged at home and where the almoner has to plan further institutional treatment, either at a small nursing home or a convalescent home, or possibly at the local Municipal Hospital.

With the patients attending the out-patient department, in instances where rest is an essential part of treatment it is often necessary to help the patient to reorganize her life. A daughter may have to be kept at home, a relative summoned to assist, or a woman hired to help with the heavy work. Again, it may be a question of contrivance and planning, or it may be a matter of putting the patient in touch with a society who will help to make such a plan possible.

The Chronically and Incurably Ill.

For the chronically and incurably ill patient the almoner's plans may have to cover the whole of the rest of his life. It may be possible for nursing and care to be provided at home, probably under the supervision of a district nurse, but if this is impossible the patient may have to be moved either to a Home for Incurables or to a local municipal hospital where provision is made for chronic cases, or at the last stages of illness to one of the Homes for the Dying.

When for medical reasons institutional treatment is absolutely necessary great care must be taken to find a home as near the patient's own home as possible so that he may not be entirely cut off from old associations and his old life, and friends and relations can constantly visit.

The natural instinct of mankind, however, is to cling to the familiar and the known, and to prefer when possible to die at home, however poverty stricken and inadequate that home may be. Sometimes this can be made possible by slightly supplementing the patient's income, while his comfort can be increased by the supplying of invalid appliances and extra nourishment, possibly by the provision of a wireless set. Often added to the tragedy of illness and of pain is that of loneliness, so often borne with amazing fortitude, the flower of stoicism, or of some deep inner contentment. It may be helpful to link up the lonely man with some Church organization, or to find someone who will visit from time to time, who will take in books, newspapers, flowers, and with friendliness and understanding will bring outside interests to a life which would otherwise be bounded by pain and by the four walls of a sick room.

Misfits.

Some of the most difficult of medico-social problems are those dealing with physical and mental misfits. On the one hand the cripples, possibly disabled by an accident or by some industrial disease, the blind and the deaf; on the other the mentally handicapped and the problems of character.

The patient with a permanent physical disability is one to whom economic considerations are of supreme importance. When the fact that his trouble is incurable is accepted by his family, there is a risk that one of two attitudes is likely to result. Either they will ignore his claims to a full personal development, not out of unkindness but in the wear and tear of daily life, or they will instinctively treat him as a somewhat immature being whose condition is pitiable and who must therefore be protected. Both sentiments arise from the false idea that a partially handicapped person has no further part to play in the workaday world, and both overlook his rightful claims as a human being. From the beginning a true appreciation of his position must be fostered, allowances will have to be made for his shortcomings, but he must be encouraged to labour to the full measure of his strength. In helping him to find work, the almoner must keep two considerations in mind: first, its suitability from the health point of view; and secondly, its economic value; for if he can contribute a share to the family budget his importance will be enhanced and his self-respect ensured. It may be possible to persuade a sympathetic employer to give the man a chance in his former work, or if his disability is too great for this it may be a question of training him for something new. There are special workshops for the blind, and in some parts of England there are training centres for the tuberculous and for certain crippled people, but, except in the case of the blind, the organized schemes are still incomplete and, at a moment when it is difficult for the able-bodied to find work, it is doubly difficult for the man or woman with a serious physical handicap.

Apart from the employable cripples are the unemployable, whose physical disability is too great to make a normal life possible, but even these need not suffer from the curse of enforced idleness. Many can be taught handicrafts which may bring in a little pocket money and will certainly be a joy and interest.

Assistance for those of the mentally handicapped for whom there is no hope of cure is inevitably more limited and somewhat negative in character, as the aim is preventive rather than constructive. If the patient can be looked after at home

then in some cases it may be better to be there rather than in an institution. It is illuminating to see how at times good comes out of evil, and the member of the family, who, owing to physical or mental disabilities, can be no help economically, and who from a worldly point of view is nothing but a burden, yet calls out a great tenderness and beauty of action from its other members. In other cases a patient either cannot be adequately looked after at home, or else imposes too great a strain on his relatives, and must be placed under some sort of restraint in a special institution.

Possibly the most difficult problems of all, and the ones which demand the most intensive and personal work from the almoner, are the men and women whose physical ills are the direct outcome of their character and of their own actions. The man whose work and responsibilities make claims on him which he is unwilling or unable to fulfil, may find a subconscious refuge in illness. His ills may be dealt with by the psychiatrist alone, but more probably the almoner is called on to play her part as well. Dissatisfaction with life, a disinclination to face reality, may account in certain instances for the problems of the unmarried mother, the drug taker and the prostitute. Each come up to the hospital for some definite physical ill, but each in all probabilty needs social in addition to medical help if adequate good is to be gained from hospital treatment. A flood of light has been thrown on such cases by the researches of recent years, and the social worker who was formerly struggling with character problems which seemed insoluble, now finds herself one of a band of workers who are facing the difficulties with increasing knowledge and scientific methods.

General Problems.

In a voluntary general hospital emergencies are rather the rule than the exception. A patient arrives alone who is in urgent need of admission, but there is no bed vacant and he must go to his local municipal hospital. The proper authority is approached and a bed secured, but the patient is too ill to travel alone and the almoner may be called on to find an escort to travel with him. An in-patient is ready for discharge and his relatives unexpectedly fail to arrive to take him home. Somehow or other the almoner must get in touch with his home and make rapid plans for him if for some reason at the last moment he cannot return there. The out-patient is unexpectedly admitted and the almoner may suddenly find that without any warning she has to take

charge of an entire household, find someone to look after them, distribute the children among friends or even place them temporarily in homes. Possibly a patient in the ward whose home is far away is critically ill. Relatives and friends arrive knowing no one in the town and the almoner has to find somewhere they can stay. A convalescent home rings up to say that a small boy has disappeared and is believed to be heading for home, and the hue and cry has to raised to find him.

If emergencies are varied so are the general problems which are part of an almoner's daily work, and they are difficult to place in any category. There are the problems of bad housing and unemployment, the two rocks on which at present much constructive social work is bound to split. In definite cases the almoner may be able to awaken a landlord to the need for improvement and repairs of faulty houses. She may even be able to secure good accommodation for an individual patient whose health is suffering from unsuitable conditions. In employment she can sometimes fit the right person to the right job, but in these matters her contribution can, as a rule, only be to the individual patient and not to the problem as a whole.

Aged patients occasionally attend who are dragging out a lonely existence in one room, which they are too infirm to keep clean, and for these an almshouse or Home of Rest may have to be sought or a woman paid to care for them, or even some regular visitor found who will at least be able to take in some breath of air and light from the outside world. Permanent homes must sometimes be provided for children. A mother dies and leaves a young family and no one suitable to look after them. The father has to be out at work all day and the paid housekeeper may possibly not be reliable. It may occasionally be better to place them in orphanages where at any rate good care is assured, and where opportunity for the father to visit them regularly is given; though more and more the experienced social worker inclines to the view that home life, even of an indifferent quality, is less likely to be disastrous than an institutional upbringing, however excellent.

The list could be continued almost indefinitely. The almoner is placed in a hospital to help the patients who are in difficulties—it is obvious that the difficulties will be as diverse, as multitudinous, as the patients themselves.

Social Work in Municipal Hospitals.

As has been stated in Chapter I, there is a dual system of hospitals in England. On the one hand, the voluntary

hospitals depending largely, though not wholly, on the charity of the public, hospitals with great traditions and great teaching schools; on the other hand, the municipal hospitals, which till 1930 were workhouse infirmaries managed by the Poor Law Authorities, but are now State-run hospitals, often of a high degree of efficiency, which are turning, some slowly, some rapidly, into fully-equipped centres for the treatment of disease.

There seems little reason to doubt that social service departments, which are now widely recognized as an indispensable part of the equipment of an up-to-date modern hospital, will be included in schemes for future development. So far, a few of these hospitals have appointed almoners, and the medico-social problems with which these almoners are faced are much the same as the problems in the voluntary hospitals. One of the most difficult of these, the provision of necessary care to the patient who has to be discharged in an early state of convalescence to make room for someone else, is, however, much modified, because of the greater number of beds usually available in a municipal hospital. The comparative number of chronically ill and aged patients in the average municipal hospital is much larger than in the voluntary general hospital, and therefore, in proportion to the total number of beds, the number of patients for whom constructive planned assistance of one sort or another is needed on discharge is smaller. On the other hand, there are many minor problems which arise to worry the chronic hospital patient by the solution of which the almoner may be able to bring peace of mind. There is also, undoubtedly, as much scope as in the voluntary hospital for someone who is in a position to act as liaison officer between the hospital and various municipal departments and voluntary agencies which may be interested in the patient or from whom he may require help.

After all, whatever the type of hospital, whatever the setting, problems of sickness, of poverty, of erring human nature, cannot fail in large part to be the same all the world over.

The Prevention of Hospital Abuse.

The question of hospital abuse is an increasingly complex matter. Owing on one side to a general change in the distribution of money in the country, and on the other to the growing costliness of modern scientific medicine, the hospitals now open their doors to a far larger section of the public than

ever before. There is no longer a clear-cut division between a "hospital class" and a "non-hospital class"; and yet, so long as hospitals are charitable institutions served by doctors unpaid for their services, the basic principle remains as important as ever that the hospitals are for those who cannot afford to obtain the private treatment required. So long as this rule is observed the spirit of the founders of hospitals is not violated.

In recent years various private schemes of insurance against the expenses of illness, in addition to the State Health Insurance scheme, have sprung into being. Here a firm will contribute a yearly sum to the hospital to entitle employees, whose wages do not exceed some definite amount, to attend a hospital free of charge whenever necessary; there the workmen themselves, or heads of families, will contribute weekly either to a particular hospital or to a general hospital fund to cover the cost of illness either of themselves or their families, and so on in great variety. These schemes are far from covering the whole ground and probably never will, though in certain places they reduce the necessary field of inquiry.

The question still remains whether the decision as to financial eligibility or non-eligibility for treatment of patients who come outside any contributory scheme should rest with the almoner or with an inquiry officer appointed solely for the purpose. Certain hospitals, but only a few, regard any form of inquiry as savouring of police work and prefer that their almoners should have the more gracious task of concentrating purely on social work; but there are strong reasons why it is preferable, when possible, for this side of the work, which is no easy one and which demands the qualities of a judge able to weigh one fact against another with strict impartiality rather than those of an inquisitor, to be in the hands of a skilled and trained social worker cognisant of medical matters and, above all, having easy access to members of the medical staff.

It is clear that the problems cannot be settled by any rule of thumb and there can be no hard and fast income scale of eligibility. The man who can afford private treatment for a sprained ankle or can pay for a minor operation may be totally unable to pay for radium treatment for malignant trouble or for an operation for appendicitis. The insured patient will have to return to his panel doctor for a lesser ailment for which no specific hospital treatment is needed, but is welcomed by a hospital for treatment if he is suffering from some obscure or serious illness or some trouble which

demands the use of special apparatus which the private doctor does not own, and so on, *ad infinitum*. There are always several aspects to be considered—on the one hand the patient's actual financial position and his liabilities (compare a man with six dependent children and an invalid wife, and an unmarried man without dependents earning exactly the same income) and, on the other hand, the diagnosis and prognosis, the facilities outside the hospital for private treatment and its probable cost. It should be noted that at the present time a great many middle-class people come perforce to the general wards of hospitals for operations because of the inadequate supply of good and inexpensive nursing homes. This arrangement is quite profitable to hospitals, but so unfair to the struggling younger members of the medical profession that it is to be hoped it will shortly be remedied by the provision of more accommodation for people of modest means. Some of the hospitals are already setting aside certain wards and rooms on a paying basis to meet this need, but the demand at present far exceeds the supply.

The question of deliberate hospital abuse is less pressing than in the days before any inquiry was made, but it still exists. There are a few people whose enthusiasm for gaining something for nothing will lead them to wait in a crowded out-patient department of a hospital rather than meet the expense of medical treatment which they can well afford. "This patient could perfectly well pay to consult you privately and I have advised her to do so, but she insists on coming to see you at the hospital," wrote an irate private doctor to a consultant not long ago. Such patients receive short shrift. Fortunately they are few in number.

It is sometimes very difficult, however, not to be deceived by the person who, to the superficial glance, appears the typical patient in poor circumstances, but who in reality runs a prosperous business in a back street, probably owns property and has a good bank balance, and is often better able to pay for private treatment than others who have more liabilities and a higher standard to maintain.

Long experience of the out-patient department of a big hospital, however, brings the belief that more people come wrongly to a hospital from ignorance or from muddle-headedness than from any intention to deceive. There is the wanderer from abroad, rather vague as to English customs; there is the person in good circumstances who has heard of a fine cure lately performed by the hospital on one of her poorer friends, and who believes that hospital treatment is better than anything else in the world; or the patient who has heard

that hospitals are in need of money and therefore thinks it would be a good thing to attend and make a handsome donation rather than pay a fee to a Harley Street doctor, not realizing apparently that Peter may have every right to resent being cheated in order that Paul should so generously be paid. Then, again, there is a class of patient, increasing in number during the present time of financial difficulty and typifying a certain weakness of the modern outlook. This is the man or woman with a reasonably good income who lives up to the hilt, puts nothing by, and considers that if he or she is ill hospital treatment is theirs by right and not by grace. When questioned as to their financial position, their attitude is that, at a sacrifice, they could afford to pay for medical treatment, but that there are so many other ways in which they prefer to spend their money!

Added to these are the patients who could afford to pay a consultant's fees once, but for whom the cost of prolonged private treatment would be prohibitive, and for whom some arrangement must be made which is fair to all parties.

Arrangement and Collection of Patients' Donations.

Closely interwoven with this question of financial eligibility for hospital treatment is that of the arrangement and collection of patients' donations which, as a rule, forms part of the almoner's duties, and may even be the main reason for her appointment.

After the War most of the hospitals decided to make some charge to the patients, both because of increasing expenses and the inadequacy of their post-war incomes, and because they were serving a section of society some of whom could afford to pay part, though not the whole of the cost of treatment. There was much discussion as to whether a flat or a movable rate should be charged, and whether special officials should be appointed to collect donations or whether the almoners who were already dealing with the patients should assume this responsibility. There was considerable difference of opinion. Certain hospitals decided on a small fixed rate for out-patient attendances (which could be remitted when necessary) and a sliding scale for in-patients; other hospitals decided on a sliding scale for both; some appointed new officials, others gave the work to their almoners.

A small flat rate has the advantage that it can be collected mechanically and cheaply and brings a definite, if limited, income to the hospital. On the other hand, the disadvantages are

many and obvious. If the levy is to be at all general it has to be fixed at a small sum, for otherwise it will tend to keep away patients who really require treatment. However small, it will press heavily on the person living on a bare minimum—the man in receipt of unemployment benefit or the widow with a young family—and it will be a totally inadequate and absurd contribution for many of the people who are legitimately attending the hospital.

The arguments in favour of the almoner's being the arbitrator as regards suitability apply equally strongly to her having the matter of patients' payments in her hands. To make a decision of what is fair to the patient and fair to the hospital is never particularly easy. It can only be done adequately by a person who knows from what complaint the patient is suffering and has the opportunity of consultation with the doctor about the general prognosis, and how long the patient will have to be away from work and whether he will ever again be well enough to be a wage-earner. It is important that this should be in the hands of someone with the power to readjust a decision if unexpected factors alter the case. Even with her special knowledge, a right decision is often a matter of extreme difficulty. She is naturally desirous to foster the patient's spirit of independence and of generosity, and yet has to ensure that the payment does not cripple himself financially and lower the standard of family life to any serious extent. It surely needs the wisdom of Solomon to come to any right decision when a patient is suffering from the early stages of a disease likely to prove fatal, who at the moment is in a position to pay something for treatment but whose income in the future will probably be inadequate for his needs. How far is the contribution to be decided on the present position? How far is the future to be taken into account?

If the almoner deals with donations the inquiries she is called on to make can serve a double purpose. The same questions bring to light what, if anything, the patient can afford to do for the hospital, and on the other hand what must be done for the patient in addition to medical assistance if he is to get full benefit from treatment. This means economy of time and energy, and, more important than all, a sparing of the patient's susceptibilities by avoiding an overhandling of private affairs and unnecessary repetition. Another reason why it is advantageous when possible for the almoner to deal with the question of donations is that in order to do so she has to see and form a slight personal contact with every patient, instead of only seeing the patient who is referred to her for help, or for whom some special recommendation is

made by the doctor, as happens when social work is her sole duty in the hospital. This means that she is able to select her own cases for assistance, and that she has the opportunity of detecting social trouble before it actually arises, and often of arranging help before a patient has fallen into the "morass of destitution" rather than in spending time and money in the far more hopeless task of helping him out of it. She has a chance in this way to save a vast amount of suffering and to do some really constructive work. The beggar in rags, who has lived on his wits for years, fills the almoner with as deep a despair as the case of inoperable carcinoma fills the surgeon. How much might have been done had the trouble been taken in time! To an almoner preventive social work is as precious as preventive medicine is to a modern clinician, and the two aspects of the one problem are closely connected.

An objection is sometimes made that if an almoner is connected inseparably in the patient's mind with the question of money, he will not turn to her for assistance in his difficulties, and, also, her "touch" (whatever that may mean) in social work may in some way be spoiled and blunted. If this is so she is indeed a poor social worker! For better or worse one of the main threads of life is money. The average patient at hospital does not resent being asked for certain details when he clearly sees the reason. The social worker who has "the root of the matter" in her is able to keep a proper sense of proportion and give each side of the problem its due weight. The quick reaction of her sympathies and understanding is not checked by the fact that her feet are planted on the solid ground of fact.

It must not be forgotten, however, that while the almoner is probably the most suitable official to deal with the matter of patients' payments, there is a serious risk unless the department is adequately staffed that this side of the work, which is naturally of extreme importance to the hospital, may take up so much of her time that the social service, which is of vital moment, may be hurried and poor in quality.

Other Administrative Work.

During the last few years the almoner has tended to become more and more closely connected with the general administration of the hospital, and in particular with any administrative work directly concerning the patients.

The details vary in different hospitals but, just because the almoner has so many facts and figures in her hands, collected

in the course of her ordinary work *à propos* of patients, she is often made responsible for such diverse matters as claiming grants from Approved Societies towards the cost of hospital treatment, making claims on behalf of the hospital under the Road Traffic Act, and preparing statistics in the maternity, tuberculosis and V.D. departments in order to obtain a grant from the State.

This unification of work into one department has the advantage of securing economy of labour and of saving the duplication of records; but as with the collection of patients' payments, so with the increase of administrative duties, there is a grave risk that, unless the almoner has a really adequate staff of assistants and of clerks in her department, her real work, which she alone can do, may become hurried and sketchy or even be crowded out of existence. She may cease to be a working partner in the team of doctor, nurse and social worker, struggling to cure and to eliminate disease.

To quote Sir Charles Loch, the attempt to accomplish too much may mean "busy stagnation in a restless office. There may be much registering, some referring and some considering, but in the main the essential conditions of each case will not be grasped. There will be no feeling of securing that what is done is truly and effectively done. There will be all the difference between building on rock and building on sand."

Co-operation.

Sir Charles Loch once wrote of almoners' work as being in a sense "the child of my own thoughts." It is only fitting, therefore, and only to be expected, that work which was originated by one to whom scientific charity meant so much, should have as its keynote co-operation and co-ordination, mutual and co-operative effort both within the hospital and without. In the hospital the almoner should be quick to know what social information will be helpful to the doctor, possibly in diagnosing, certainly in treating, a case. She should see that information which is needed is passed rapidly from one department to another, to save trouble for the staff and unnecessary investigation and fatigue for the patient. She has to act as liaison officer between the hospital and the outside societies and agencies, and has to have a detailed knowledge of the nature and the type of work done by each of the latter so that she can readily advise the patient of the appropriate source of help, either State or voluntary, to which it is advisable to make application.

It would not be desirable, even were it possible, for the almoner to carry out effective social work without this co-operation, as it would mean narrowness, lack of strength, and an overlapping with work which is being done outside the hospital.

She is largely dependent on outside assistance for funds as, although hospitals as a rule possess a Samaritan Fund, it is rarely sufficient to provide all that is needed for patients. But it is not only on funds but on local understanding and interest that the almoner depends to enable her to carry out what is needed. It is often not a question of material help, but of home visiting, of reports, of advice, for which the almoner turns for assistance to these agencies. She, on her side, thanks to her official capacity in hospital and to her opportunity for personal consultation with the medical staff, is in a position to give valuable help to the outside societies. This united work is an effort to yoke the resources of the community for the benefit of the patient who is in need.

It must be noted that the almoner, when she refers a case to an outside source of help, does not by any means lose personal contact with the patient. Without this her knowledge of the situation would become superficial and her action as "director of forces" in bringing together the work of doctor, patient and outside agency, would rarely reach a satisfactory conclusion. She remains in touch with the patient, ready to play her part in any plan of help which is made.

A great difficulty is found in some of the provincial towns and in country areas where the outside agencies are few. The almoner is perforce able to cover a much smaller field and more demand is made on her own initiative and resource. By the force of her need she is sometimes instrumental in bringing voluntary societies into being, but unless she can do this she has to be content to deal with fewer cases, to deal with them less adequately, to pay home visits herself in her leisure hours, and if possible employ any volunteers whom she can find to work for her.

She probably has a difficulty over funds, for as a rule if her Samaritan Fund exists it is small. On the credit side of the account, however, she can depend on a local patriotism which is unknown in a town where organized charity is all-important. In a village little is private or hidden and the amount of interest shown by everyone in everyone's business, though sometimes disconcerting, may be a real asset in time of need. Someone will organize a concert or whist drive for the family who are in trouble, and neighbours hasten to the rescue, quick to offer their services to care for a child whose

mother has gone to hospital, to share in the nursing when she returns, to give eggs and home-grown vegetables or even a chicken to the household afflicted by sickness.

In many parts of England the old feudal system which has so much both to its credit and discredit is still very much alive. The richer people in many cases assume a burden of responsibility for the sick and needy of the district, particularly for their own employees, and may often not only give material help over a long period, but also keen personal interest. In this general neighbourliness the almoner in a provincial hospital will often find compensation for the lack of organized charities.

Almoner's Records and her Place in Medical Research.

Although in certain branches of work the almoner has played her part in medical research, it seems as though much greater demands will be made on her in the future. More and more it is realized that in a great number of diseases it is impossible to divorce illness from the patient's life as a whole, from "the weeping and the laughter, love and desire and hate," which make up such an important part of life, from his mental and emotional history, from his environment and his economic condition. All these factors have to be noted, and form a background in the mind of the doctor engaged in research.

The almoner, like most other modern social workers, has her own system of correlating information, a system which may vary in detail in different hospitals but which has essential features in common. To secure continuity in work which may have to be undertaken on behalf of an individual or a family by successive almoners, as a prop to her own memory, for the teaching of students (training under her to become almoners), and for statistical purposes, she has to have as exact a record as possible of the work she has undertaken. She has her day sheets and case papers on which she records the facts learned about patients, and she has her registers and her card indexes. She therefore starts with the advantage of her own records of patients seen at hospital from which to collect information. If this is not sufficient for the purpose she has facilities with which to acquire further and fuller information. She has the opportunity of learning something about the patients at their own homes, in their normal surroundings, at their work and in their

amusements, of gaining knowledge about the family history and of reporting to the doctor on whatever particular aspect he requires. She brings a trained mind to bear on the collection of facts and on the problems involved; she has learned in the course of her work to sort out the relevant from the irrelevant, true from false, and to prize accurate information as a precious jewel. Moreover, beyond the collection of facts and of information for the purpose of supplementing and completing a definite piece of medical research, she has a part to play in any "follow-up" scheme which is so often a necessary antecedent to gathering material for further research. When desired she can get news of patients who have ceased to attend the hospital, and often by a personal knowledge of their circumstances can persuade them to report at hospital when necessary, when a formal letter would have little effect. She knows when it is too arduous for the patient to attend unaided, when a car for the journey has to be borrowed from some kind friend or even an ambulance hired, when the patient's courage will run out of his finger tips at the very sight of the hospital and can only be reinforced if an escort is supplied, or when clothes are at such a low ebb that a little judicious help is needed before the patient will agree to a medical examination, however necessary.

Interesting "follow-up" work and investigation from the social service angle, both for purposes of research and for the prevention of unnecessary suffering, have been done either continuously or from time to time in such widely different diseases as rheumatism, pulmonary tuberculosis, carcinoma, diabetes and gastric disturbances. In certain hospitals there is a complete record of all the patients suffering from certain diseases and research is systematically pursued at the same time from the medical and from the social side.

The almoner has yet another duty and another contribution to make in the name of research. The evils with which she has to contend each day are not only due to causes for which at present no cure has been found, nor to the financial distress and the ignorance of the patients themselves. They are also due to the lethargy and ignorance of the general public. The almoner, by her careful keeping of social service records over a number of years, is able to produce exact facts and figures and has valuable material for research into the connection between social conditions and certain types of disease. But more than this, with the prestige and the weight of the hospital behind her, she has a forceful weapon with which to waken the public conscience to the need for concerted action and reform.

Much suffering is beyond man's present power even to touch, but there is still much which is due to ignorance, to pettiness and to an acceptance of injustice. To whittle down poverty to its lowest denominator, to lessen the appalling weight of human suffering, to make life more reasonable not for the few but for the many is the object of every almoner—

> "For life is colour and warmth and light
> And a striving ever more for these—
> And he is dead who will not fight
> And who dies fighting shall have increase."

As with every social worker, she is striving all the time for a state of society where her work will cease to be needed, but the goal is still far off.

CHAPTER IV.

CERTAIN ASPECTS OF ALMONERS' WORK.

1. In a Clinic for the Treatment of Venereal Disease.

AS a result of the recommendations of a Royal Commission on Venereal Disease which were published in 1916, the Local Government Board required all local authorities of England and Wales to participate in the scheme for diagnosis and treatment which came into force in January, 1917. It was ruled that the work should be carried out in connection with voluntary hospitals and in London alone over twenty clinics were established. At first these clinics were limited to certain hours; but the arrangement soon proved quite insufficient to meet the volume of work and needs of the patients, many of whom found it difficult to attend at the time specified. The first step to remedy these defects was made at St. Thomas's Hospital, in 1919, when the clinic was transferred to a specially designed and equipped department in which patients could be seen daily between the hours of 10 a.m. and 10 p.m. Since then the London County Council has arranged for six all-day clinics which cover the greater part of the metropolitan area, while at others the work is still carried on during certain hours.

This brief outline of the circumstances which led to the establishment of clinics, so widely spread, shows that the matter was considered both urgent and important by the Ministry of Health, and that much depended upon the response made by patients to these greatly increased facilities for treatment.

At the outset, in some of the hospitals where social work was being carried on, the medical staff was able to refer to the almoner patients whose circumstances threatened to interfere with the continuity of their treatment or to lead to the spread of infection.

The patient's first visit to the clinic often revealed distress of mind as well as disease of body, and on occasions it seemed imperative that help of other kinds should be forthcoming if regular treatment was to be ensured. Habits of life,

economic conditions and other personal matters had in some cases to be adjusted before there was much hope that the object of the clinic could be achieved. It was for this purpose that the medical staff availed itself of the help that the almoners could give.

Although almoners had been at work in hospitals for twenty years, the Almoner's Department of St. Thomas's Hospital, previous to 1917, was the only one in which the social difficulties of infected patients were being systematically considered with the object of helping them to complete their treatment, and if help was desired to overcome their personal troubles consequent upon their illness. That these difficulties present problems different from those of patients in other departments of the hospital and require special attention arises from the fact that venereal disease has, for so long, been associated with conduct which diverges from a certain standard, and the sufferer is liable to lose caste in the eyes of his neighbours. It was important that any fear in the patient's mind of discovery by relations or friends should be allayed and confidence encouraged if the clinics were to fulfil their purpose. For this reason the Ministry of Health imposed a stringent rule of privacy to protect the identity of the patient, and also removed any financial barrier by offering treatment free of charge in case considerations of expense might deter the patient from seeking qualified advice.

The first of these rules has proved a boon to the patients. The relations of the almoner to the patient in other departments of the hospital are, of course, confidential; but plans for help can usually be worked out in co-operation with other agencies unless the patient raises an objection. In the venereal clinics the patient is entitled to consider her attendance entirely a matter between herself and the doctor, and social work undertaken by the almoner which involves application to other agencies, relations or friends, must be done with the consent of the patient and with the approval of the medical officer.

To suppose that a large number of patients attending every clinic are prostitutes is a mistake. It has been found that, with the exception of one or two clinics, after excluding the cases of innocently acquired infection and congenital syphilitics, only a very small proportion of the remainder are found to practise prostitution.

Among those who learn the nature of their complaint for the first time, married women infected by their husbands probably endure the most acute distress. Fortunately the knowledge of the cause of the illness often comes slowly,

and they have time and opportunity to adjust themselves so that the disintegration of the home seldom follows. Where the knowledge comes suddenly and there are perhaps other sources of unhappiness in the background, the patient may feel that home life is no longer possible. To these the almoner can suggest a consultation with a Society which will give advice from the legal point of view. Such discussions frequently lead to a reconciliation, or if this is deemed inadvisable, free legal aid can be given to take such steps as appear to meet the case. The courage and forbearance with which some of these women face life is often striking.

The greatest opportunities for service are, without doubt, given to the almoner by the single woman and girl coming from widely divergent classes of society. Her aim is to understand the patient's state of mind, ambitions and recreations, and to visualize her home and industrial situation. Assistance and enlightenment can be given by explaining what is done to expedite cure; and, if necessary, what agencies and individuals can help outside the hospital. This takes time, but as the opportunities for meeting are frequent, a real interest may develop between them which often brings mutual understanding and help. The word "mutual" is used advisedly as it must be borne in mind that different standards are respected by different sections of society.

As the patients attending the clinics increased, it rapidly became apparent that the existing accommodation for infectious cases living in unsuitable surroundings was inadequate. Girls sharing a room, sometimes a bed, friendless or unwilling to apply to relations and friends, needed a place in which they could stay while receiving treatment, and until they were able to resume a normal life. Some could be referred to the London Lock Hospital, others to the local infirmaries, but many presented problems which required a different environment and more individual and sympathetic consideration than would be possible in large institutions.

To the Southwark Diocesan Council must be given the credit for pioneer work in this connection. As early as 1913, a Refuge was opened in Woolwich for cases during the infectious period. Five years later, two more hostels were opened: one, in the north of London, for the reception of cases from various clinics, and in the same year, 1918, with the permission and help of the St. Pancras Association of the London Diocesan Council for Preventive Rescue Work, the Royal Free Hospital was able to use a small house in the neighbourhood for its own patients. A fourth hostel was opened in connection with St. Thomas's Hospital in 1920, with thirteen beds taking both

pregnant and non-pregnant cases. Voluntary effort, aided by the London County Council, was responsible for this extension of the work of the clinic which provided a means of help to the patient both from the medical and social point of view. The experience of twelve years has shown that the need for the hostels was not temporary, and further developments have gradually taken place. In 1920, the Metropolitan Asylums Board opened a hospital for women and girls in Sheffield Street, which has since been transferred to the London County Council.

There are now three hostels working in connection with the clinic at the Royal Free Hospital, providing fifty-eight beds for girls and thirty-one for babies. One of these hostels is administered through the generosity of the West London Mission, and two by the Committee of the Incorporated Hostels of the Royal Free Hospital. The Jewish Association for the Protection of Girls and Women also takes a few cases requiring treatment in their Home at Shepherds Bush, and in 1918, the Southwark Diocesan Rescue and Protective Association transferred the Woolwich Hostel to a more central position in South London. This Home is for quite young girls, as it is often undesirable for children of fourteen and fifteen to mix with girls who are older and more sophisticated. In Clapton the Salvation Army has two hostels where most excellent work is done.

The medical hostels in London are conducted on undenominational lines and are open to women and girls of any social standing. Their primary aim is to prevent the spread of infection by those patients whose home conditions or other circumstances make it difficult or impossible for them to take the necessary precautions to avoid the risk of infecting others. The medical officer of the department directs the treatment given in the hostel, and all the patients visit the clinic as often as is necessary. Residence in the hostel thus ensures regular treatment and provides the patient with appropriate food, rest and occupation. In some cases this seems to be all that is required until the infectious period is over, and ordinary life can be resumed, but often the patient asks for additional help of another kind. She may be homeless, workless, destitute, pregnant and possibly deserted by the man she hoped to marry. A glance at the annual report of the hostels shows the immense difficulties and, at the same time, the very great encouragement the staff and workers experience in trying to meet those needs.

Admission to a hostel excludes the patient from all her usual social environment and her tendency is to concentrate

on her physical disability. To counteract this inclination as much occupation as the doctor thinks advisable is given, and she usually takes her part in the routine of the Home. Classes, lectures, games and expeditions are organized to awaken her interest and broaden her outlook, with at times remarkable results. The following shows how a girl who is determined to make something of her life can be helped. X.Y.Z., an unmarried girl with a baby which subsequently died, was herself one of three illegitimate children. Her desire for attention at first manifested itself in a tiresomeness which tried the patience of all, but her genuine wish for a better education was realized. She attended London County Council classes in French and shorthand and it was found that her ability was above the average. During the next eighteen months, while working as a maid, she not only earned and made her own outfit, but attended evening classes as well. After a successful year at a Working Women's College, it was found that lack of elementary instruction prevented her from becoming a teacher. Nursing was the career she chose and she is now a state registered nurse, having passed both the State and Fever examinations with ease.

Many, through mental instability or difficulties of temperament, are unable to avail themselves of the help which others value. The other side of the story is illustrated by the following: A.B.C., age seventeen, when too ill to carry on with her irregular life came to the clinic for advice and was glad of the offer of a vacancy at the hostel. She had run away from home in the Midlands a year previously, found work in London, but drifted into ways of supplementing her wages. At first she would neither reveal her name nor the whereabouts of her home. At the end of six months she returned to her parents, only to appear at the hostel again a year later begging that work should be found for her in London. This was done, but before the end of many weeks she was again earning money by immoral means. Later she asked to be sent to a training home, but before this could be arranged she ran away taking a younger girl with her and both were found to be leading a life of promiscuity among coloured men. With difficulty, she was persuaded to give this up and to go back to her home where, for a year, she worked and was an active member of a girls' club. A fourth time she came to ask for advice and help, as she had returned to London and become pregnant.

In the hostel, the number who find moderate discipline irksome is small; the majority co-operate willingly in the efforts to help them regain their self-respect, if they have lost

it, and look forward with confidence to the future. Many return to their previous occupations, but the few who have never had any regular work and have drifted from one employment to another are more difficult to launch successfully.

The outlook of the girl with the responsibility of a child is a different problem, and every effort is made to obtain an affiliation order for the father to contribute towards its maintenance and, if necessary, legal action is taken. Even when an allowance is obtained from the man and paid regularly, the financial aspect is one of great difficulty, particularly if the mother has no skilled occupation and is unable to earn sufficient to pay the cost of a foster-mother. In these circumstances an appeal to charitable funds is necessary. Many girls marry and, if the future husband is willing, the child is able to share the home.

When it is deemed advisable, from the medical point of view, for the mother and baby to remain together under supervision for a period of from six to eighteen months, admission to a special hostel is arranged where the baby is cared for and from which the mother may go to work. In some cases a vocational training can be obtained in a home where non-infectious patients are received. No girl or baby leaves the hostel without a plan being made for their future, and to keep in touch with them after their discharge forms a large and important part of the scheme. All patients are welcome to the hostels at which they have been treated, and the large parties at Christmas-time are evidence of the many happy relationships which have been established. To quote from a report of ten months' work by the After-Care Worker associated with two hostels, "Four hundred and thirty-one letters have been written in connection with these girls, and I have paid two hundred and seventy-nine visits."

The children who come to a venereal clinic fall into two groups, those whose infection is inherited and those infected accidentally or by assault; the last are happily few. For all these children treatment over a long period is necessary, and much can be done to allay the fear and tediousness of attendance by providing games and books. A child who is excluded from school for reasons of infection or whose home conditions are unsuitable is, subject to the consent of her parents, frequently transferred to a home. In 1921, the Federation of Children's Rescue Committees opened the Children's Medical Home, Waddon, where there is now accommodation for thirty-nine children between the ages of 3 and 14. The home is an adapted country house with a large garden. The children of school age have regular lessons,

often in a covered playground with open sides. Handicrafts play a large part in the curriculum, and everything possible is done to try and give the child a happy time. The benefit of being in a home where both treatment and education can be continued under ideal conditions is patent. The almoner's work for children would be limited if it were not for the valuable co-operation of the Children's Worker. She visits the home, making friends with the parents, and ensures that proper accommodation is available for the child when she is fit to return. Where out-patient treatment is all that is required for those who are non-infectious, the Children's Worker urges regular attendance and herself often brings to the clinic a child who would otherwise lapse. In rare instances, and with the permission of the medical officer of the clinic, the National Society for the Prevention of Cruelty to Children is asked to visit the parents of a child who should be treated. This step rarely fails to have the desired effect. As regularity of attendance is usually of vital importance, it is part of the almoner's work to see that the patient follows the doctor's instructions on this point, and to watch for re-attendance. To those patients whose attendances are overdue, letters may be written or occasionally a home visit paid, but only with the greatest care to safeguard the confidence of the patient.

No patient need stay away through lack of means to pay her fare. The almoner is able to bring to the notice of the Medical Officer of Health of the County such necessitous cases, and fares are paid by the Council even if the patient lives far out in the country, provided she attends the clinic nearest to her home.

The medical officer may ask the almoner to arrange for the attendance of a contact. It will be realized that this is a difficult matter, as the consent and co-operation of the patient must always be secured.

Under the direction of the medical officer, the almoner helps in compiling the statistics required by the Ministry of Health and London County Council. These are often most interesting studies.

Experience of social work in venereal clinics shows clearly how unjust is the too-prevalent prejudice with which venereal patients are still regarded. It is tobe deplored that, through fear of discovery, a patient should be deterred from seeking treatment. The fact that an individual suffers from venereal disease is no guide to character, and a close acquaintance with these patients calls forth respect and admiration for the courage, perseverance and unselfishness with which many face and overcome their troubles.

2. An Almoner's Work at a Chest Hospital.

There is a widely held impression that a chest hospital deals mainly with tuberculosis, and the fact is often overlooked that there are a number of other serious chest conditions which involve a severe degree of disablement and for which to-day much more satisfactory treatment is available than in former years—these include asthma, bronchiectasis and new growths, besides diseases affecting the heart.

Tuberculosis, by reason of its infectivity and still high mortality-rate must loom large, but much of the work of treatment, both medical and social, rests now in the hands of the state. By the Act of 1920 the provision of treatment for tuberculosis was taken over by the County Councils. The country is covered by a net-work of dispensaries staffed by tuberculosis officers, nurses and sometimes trained social workers. Beds for the various forms and stages of tuberculosis are provided in more or less adequate numbers by the county authorities. These schemes for dealing with tuberculosis provide one more instance of the claim, previously made, that most efforts at social betterment have been started and tried out by voluntary effort and then taken up and amplified by the state.

The tuberculous patients who come to a chest hospital may be classed in four main categories:—

(*a*) Those sent by medical practitioners for a specialist's opinion. Among these will be found quite a number of cases where a diagnosis has already been made but where the patient is unwilling to accept its implications as to treatment.

(*b*) Patients who have been attending a doctor but are "not satisfied."

(*c*) Patients who have had already a varying amount of treatment but have not responded successfully to it and come in the hope of obtaining further relief—some of these are in the last stages of the disease and the only form of help that can be given is to arrange their admission to a Home for the Dying or a municipal hospital.

(*d*) The fourth and ever-growing category consists of patients who are coming for some special form of treatment, such as artificial pneumothorax, sanocrysin, &c. Most of this category will be attending at the request of their local tuberculosis officer and one of the almoner's duties will be to see that payment is obtained from the County Councils for these cases where possible.

In all cases of tuberculosis a great deal of the spade work with regard to home conditions, &c., will be done with varying

degrees of efficiency from the local dispensaries, and in many cases the almoner's chief duty will be to act as a link between the patient whom she sees frequently and the dispensary which is geographically in touch with the home. The large amount of routine home visiting from the hospital which was necessary in the days before the universal establishment of dispensaries would to-day be not only redundant but an impertinence. Further, the teaching of general hygiene—fresh air, no spitting, wholesome food, personal cleanliness, etc., which was first attempted by voluntary agencies but a short time ago, is now a commonplace from earliest childhood and needs emphasizing rather than initiating.

It does, however, remain for the almoner to make friends with her tuberculous patients, and to become familiar with their circumstances, so that she can smooth away the obstacles which to them bar the way to treatment. To the man in the street the hospital is still "the fountain head" of knowledge, and as such its recommendations are often bowed to where others have failed to carry weight.

Perhaps the most important moment for the patient's whole future is that in which he first faces the implications of the doctor's diagnosis, and at this time the attitude is determined with which he will meet the future and whatever it may bring. At this moment too, his defences down, he will be particularly susceptible to the help which the almoner can give. The treatment of tuberculosis, extending as it does over a long period of time and involving a strong psychological element, depends above all things on the willing and intelligent co-operation of the patient, hence the importance of a social worker in close touch with the patient and possessing his confidence.

In order to enable the usual recommendation for institutional treatment to be carried out, the almoner will bring the patient into contact with those outside social agencies which exist to relieve his economic needs. These may be relatives, voluntary charities or state agencies. Her aim will be to see that the help given is adequate to the need of the patient and his family both in quantity and duration, so that he can remain under treatment for the whole period which is medically necessary for the arrest of his disease, with a mind free from the worry which is so inimical to his progress. She will need to be the whole time in close touch with any dependants he may have so that their difficulties come first to her and not to him. She will be, too, in close touch with the medical superintendent of the sanatorium who will refer to her

any social problem which is retarding the patient's recovery or threatens to cause his premature discharge. There can be no doubt that the ideal arrangement is that whereby the almoner is in personal touch with the patient in the institution as well as with his home.

When the time approaches for his discharge the almoner will see that he has suitable accommodation to return to and, in consultation with the medical superintendent and the patient, will evolve plans for his future. These may include a further period of inactivity at home, return to former or different work, or training, accompanied in many cases by regular attendance at hospital for some special treatment. At this moment again special care is necessary. For some, eager to leave all memory of their disease behind, a restraining hand will be needed—for others encouragement to take the plunge into normal activities. It is a revelation to many that the hours comprising a full working week are only about one-third of the week's total capacity, and that on the wise use of the remainder their hold on health may depend, also that the fetish of "light out-door work" is seldom the ideal, especially for the office worker or artisan. Financial assistance may be necessary to tide over the first few weeks, correspondence with employers, tuberculosis officers, etc.

Having seen the patient re-established as a normal member of the community, the almoner's duty is to "stand by" him over a period of years. As a result of her work during the previous months, the patient will have come to appreciate in the hospital a place to which he will turn instinctively in any difficulty, physical or social, so the holiday can be arranged which will prevent a breakdown, moments of economic stress can be tided over and further treatment can be arranged. With the increasing possibilities of different forms of treatment in addition to that of a sanatorium a new value is added to after-care, for where sanatorium treatment fails some other form may arrest disease even where it has gained a good hold. In all her dealings with a tuberculous patient the almoner will have in mind the possibility of infection of those with whom he has been in contact, especially of children, and will urge repeated examination of these cases.

Bronchiectasis is another chest disease in the treatment of which great strides have been made in recent years, thus increasing the scope for the almoner's co-operation. Thanks to improved X-ray technique, early diagnosis in children is now the rule, and convalescence extending over many months, attendance at special breathing exercise classes, for creosote baths, etc., will form a large part of treatment and necessitate

constant supervision by the almoner. It is not always easy to persuade parents and teachers that the cough for which the child was originally brought to hospital is but a symptom of the early stages of a serious disease. In this disease, as in tuberculosis, prolonged treatment and prolonged supervision are essential.

In asthma again modern treatment involves far more than the routine administration of drugs. For children a stay in a congenial climate where schooling is available, may be recommended for periods of several years. Funds have to be raised and parents educated. For adults regular attendance as out-patients for several years may be advised, necessitating help with fares. Sometimes a change of occupation, diet or surroundings may have to be arranged, or perhaps the patient educated to cope with his disability.

As in all other hospital social work, co-operation will be the key-note of the almoner's work in a chest hospital, primarily with the patient and the doctor, but no less with state and voluntary agencies, and her work will, if it is adequate, aim at prevention as well as cure.

Medical science is advancing so rapidly and so many new treatments for chest diseases are being evolved that research must play a large part in any chest hospital. The almoner who is already in constant touch with patients can make a valuable contribution to this side of its work by her knowledge of the patients' whereabouts or condition at any given period. Her records will be as full as possible as she cannot foretell on which points information will be required, whether social or medical. Her usefulness here will depend to a considerable extent on her friendly relations with tuberculosis officers, Medical Officers of Health and other public officials in all parts of the country.

3. An Almoner's Work in a Maternity Department.

It is difficult for those who are intimate with the work of a Maternity and Child Welfare Centre to-day to imagine the conditions existing in 1906 when hospital social work in connection with maternity departments was first undertaken. The immediate cause of its inauguration was the conviction of the authorities at St. Thomas's Hospital that the crowded Maternity Department included a considerable number of patients who were able to pay private fees. The almoner was asked to investigate the matter, and for this purpose she instituted an inquiry into the circumstances of each patient

who applied to the hospital for medical help through a confinement. This was the first attempt on the part of a trained social worker to classify the patients who received the services of this department of the hospital. The inquiry not only brought to light facts which confirmed the suspicion that some of these patients were able to make their own arrangements and pay a doctor's fee, but it also showed that, for the majority, far more than medical help was required. A quotation from the almoner's report written in 1912 gives a vivid picture of the existing conditions, a state of affairs which seems almost unbelievable to-day.

"In the maternity department six years ago the students attended all cases that applied without question of ways and means. Some of the patients were in a position to pay a private doctor's fee, others so poor that the conditions were deplorably indecent and dangerous. Patients were allowed to plead poverty, and without inquiry were supplied from the hospital kitchen with milk and beef tea which the messenger was often seen enjoying outside the gates. The self-respecting did not ask, and therefore were not expected to require help; a plausible story carried weight, and a band of far from desirable Sarah Gamps held out as an inducement for engagement that they always got nourishment for their patients. The whole district is now under supervision. Instead of treating the women for ten days and then ignoring them the patients are supervised before and after confinement, the babies are watched for a year, and by means of co-operation with local agencies the necessary nourishment is provided in suitable cases, not for a bare ten days, but for as long as the women require it. On the other hand, the women are expected to make decent and suitable preparations, and if possible to save a few pence weekly for extra nourishment."

The latter half of the above quotation sums up in a few words the result of six years of hard pioneer work. The social conscience was as yet only partly awake to the serious aspect of a heavy infant mortality, though in some districts it was more alive than in others to the means and the need for preventing this. In Manchester in the eighties, and in Liverpool during the following decade, home visiting among the mothers of young babies had been begun, and by 1906 clinics where mothers were taught how to feed and bring up their babies were already in existence. "Maternity work," involving ante-natal as well as post-natal care, had however not yet been recognized as a unit, and nothing short of this, combined with concentrated and systematic effort could make any real headway against the appalling conditions which existed.

Contrast this with the conditions obtaining to-day. It is now many years since the state has recognized the supreme importance of Infant Welfare Work and learnt that in adequate provision for the needs of the expectant and nursing mother and her child lies true economy of the nation's health. Since 1913 those who are insured under the National Health Insurance Scheme have been entitled, subject to the usual conditions, to draw maternity benefit. It is quite a common occurrence for both parents to be able to draw this, but even when only one is eligible, the benefit does much to ease the financial strain of a confinement. The Maternity and Child Welfare Act of 1918 laid on local authorities the responsibility for the health of the mother and child. The arrangements vary somewhat in accordance with the particular needs and resources of each district. In some, new centres have been set up under the direct and sole control of the local Health Authority. In other districts where voluntary effort had already stepped in to meet the need, either through the maternity department of a general hospital, or by some other organization, the state now gives a grant towards the cost of the work. The Act requires the Authority to see that there is adequate provision for ante-natal clinics, extra nourishment for mothers in need of this, Home Helps where assistance with family affairs is wanted, beds in a hospital for such as require them, and transport to the hospital. The Borough Health Visitor is in touch, and when the baby is born the mother is urged to take him to the local Infant Welfare Centre for regular supervision. The mother herself can get medical advice at a clinic if she needs this, and she may attend classes and lectures to learn how to bring up her baby. At the age of one the child passes on to the Extension Clinic where supervision is continued up to school age. It is true that, for financial reasons, every Authority has not yet found it possible to fulfil all the provisions of the Act. In many districts it still remains the as yet unattained ideal, and there is much work to be done particularly with regard to the development of Extension Clinics, as so many children lose ground between the ages of one and five. None the less great progress has been made, and the growth of the work is regarded by most students of social welfare as one of the most far-reaching experiments in social legislation that this generation has witnessed.

Yet, in addition to all this, the voluntary hospital maternity departments must continue to play an important part in the life of the community. As well as supplying the special consultant facilities afforded by a hospital, they are the chief

training ground for doctor, nurse and midwife. They also serve a further purpose, for apart from what might for convenience be termed the purely "medical" side of their training, the maternity departments provide unique opportunities in so far as they bring the hospital staff and students into direct and personal contact with the homes of the people.

It should be clear from the foregoing sketch that the efficiency and smooth working of a maternity department will depend to a very considerable degree on the extent of its co-operation with the state services. The essential need for this has a direct bearing on the details of the maternity almoner's work, for it is her part to ensure that the hospital patient is able to use to the full those resources which are placed at her disposal, and to prevent overlapping of these with the work done by the hospital. Thus each new case booked, either for the ward or for confinement at home, is reported to the local Medical Officer of Health, or the local Welfare Centre. From these sources reports on home visits are received by the almoner with reference to the preparations at home. Any instructions given by the doctor at the hospital are reported to the Medical Officer of Health, and should the mother be found to be in need of extra nourishment and unable to afford it herself, the almoner will ask that the arrangements for providing this through the Borough scheme may be put in train. When all the preparations are complete the patient is given a card which will provide her, when the time comes, with an ambulance to the hospital, or, in district cases, bring the hospital staff to her.

When the woman leaves the ward, or has been confined at home, a report is sent to the Medical Officer of Health, so that his visitor may again take over the case. In some instances, for medical reasons the mother and baby will continue to attend the hospital clinic, and so will still be under the direct supervision of the hospital doctor and sister. But in the majority of cases after they have visited the hospital again once, the almoner will be asked to refer them to their local Infant Welfare Clinic. The same routine is followed with the district cases.

Within the hospital the maternity almoner has to a special degree the support and co-operation of the medical and nursing staff, on whose advice and guidance she can base so much of her social work. The teaching in mothercraft, which is now given up and down the country, is one of the greatest educational influences of to-day.

In every case, however, there lurks the possibility that

adverse social conditions may spoil the smooth working of the national scheme. Where this occurs it is the almoner's task to try to adjust what is amiss, though only too frequently the trouble is due to bad housing conditions, where any lasting remedy is well-nigh impossible to find. In many cases the difficulties that arise are much the same as those that are met with in other departments of the hospital. Children who cannot be left while the mother is away, or is laid up; cases where special treatment or convalescence is recommended by the doctor and cannot be procured without help; delicate domestic situations which need to be handled in such a way that family unity will be retained and strengthened: these are among the maternity almoner's daily problems.

Perhaps the part of her work which makes the most searching demands upon the almoner's resources is that which concerns the unmarried mother. She comes to the hospital for many different reasons,—for advice about some other, perhaps dissociated illness, or hoping that she has mistaken the nature of her trouble, or in a desperate effort to find help. To some the situation may be the result of ignorance, or of a temporary failure of control, to a few it may be the consequence of persistence in bad company and a habitual surrender to the easier way. But whatever the background of the patient, it is essential for the success of any constructive plan for the future that she understands from the first that the almoner's function is neither to preach a moral, nor to act as a machine to turn out ready-made plans for the future. The almoner can only help in so far as she is able to establish her position as a friend and adviser who is prepared to stand by and assist when need arises, and realizes that her chief task is to foster in the girl herself that courage and determination without which her life cannot be rebuilt, for of those who have suffered disillusionment the future makes very hard demands.

If the girl has a home to which she can turn, or if the father of the child is willing to marry her, the responsibility of the almoner may cease when she sees her established in her parents' or her husband's home; but for the girl with no home behind her much care and thought will be required. It is true public opinion has become more humane than it was formerly and modern society has recognized her need, has made provision for her shelter before and after a confinement The almoner's hope of giving help would indeed be a desperate one were it not for the wonderful work of many Homes on whose ready co-operation she can always rely. But it is on

a right judgment as to what provision will best meet each particular case, and on her power to rouse the best in the girl, that the future will to a very large extent depend.

When the child is born it is the economic problem of the single woman with a child to support that has to be faced. The law of the land endeavours to make the man take his share of the financial burden, but affiliation orders are notoriously hard to enforce, even with legal aid, and it is often the almoner's task to try to help the girl to find the way to complete dependence on her own resources. It may be that here will come in the much-vexed question as to the advisability of adoption or institutional life for the child. Is it better for the child that he should share his mother's home life, even in a home that may leave much to be desired both morally and materially, or that he should grow up in a better environment with foster-parents, or with no home life at all in an institution? The daily care of her child would appear to be her inevitable responsibility, but in extreme cases this may prove to be too hard a strain, and as a last resort the almoner may be called upon to arrange for the removal of the child if the mother's sole chance of making anything of her life seems to require this.

To the almoner in the maternity department a special opportunity for constructive social work is given. Her peculiar strength lies in the fact that the majority of the patients with whom she is working are not ill, they are needing the help of the hospital, but in an experience of *normal* life. Only too often in other departments of the hospital the almoner's task is to try to put together what poverty, ignorance and disease have broken, to help the patient to make the most of what is left, and at best to try to prevent the disaster from recurring. The maternity almoner has to face these problems too, she is constantly in the thick of the fight against the forces of evil, but she has a unique chance of winning the mother's co-operation in the battle, in their common effort to give the child the best possible chance. It is strange and a little disquieting to reflect how much social work in the past has centred solely on the mother of the family; how little on the father who has an equally important, though naturally different, part to play in home life. Recently, efforts have been made by some Infant Welfare Centres to educate the fathers too in matters touching their homes and children, and those efforts have met with very beneficial results. To those who look to the "family" as a stabilizing influence in a tottering world, work in a maternity department surely offers special inspiration and hope.

4. An Almoner's Work in an Ophthalmic Hospital.

In 1920 an almoner was appointed to assess and collect the in-patient payments at Moorfields Eye Hospital. From this beginning the social service department in the hospital grew till now it covers every patient who enters the hospital doors. In the other two London Eye Hospitals in which an almoner's department exists, the appointment was also made in the first instance for administrative reasons. The social service aspect of the work has developed from the administrative.

At first sight it appears that for those who suffer from serious defective vision voluntary social service is not required, for so much is already provided by the state. Blindness has always had its own very special appeal to sympathy. In this country that appeal has been answered by legislation which may pilot the blind from the cradle to the grave, and as a corollary to this the state takes all possible precaution to prevent blindness; but state machinery is of necessity rigid, the state must legislate for the mass, and can take no account of the individual. An almoner's work in an ophthalmic hospital affords an example of how voluntary (as opposed to statutory) social work may be used to oil the wheels of legislation that they may run more smoothly for those for whose benefit they are devised. To achieve this, the almoner must have a detailed and up-to-date knowledge both of statutory Public Health administration, and of the many voluntary organizations for social service whose aim it is to help and to prevent blindness.

The special aspects of the work may best be shown if it is divided into two main sections.

A.—Prevention of Blindness.

Under this heading may be included the treatment and cure of ophthalmic disease, slight or serious. It is impossible to give more than a brief survey of the many social problems connected with eye disease, but some of the more salient points may be outlined.

1. Home conditions.

Many of the patients attending the out-patient departments of our ophthalmic hospitals come to seek treatment for diseases resulting from the dirty, poverty-stricken or over-crowded conditions of their home life. The evils of bad housing are all too well known, and to cure or arrest the

disease it is obvious that mere hospital attendance will be of little value. Either the surroundings must be altered or the patient's general health must be so restored that he may be able to combat, with success, the disadvantages of life in a slum. The difficulties of dealing adequately with the housing problem seem insuperable, but there is much that can be done. Where avoidable dirt is the cause of the disease the local sanitary authority's aid may be invoked ; in the case of underfeeding, grants for extra nourishment can be arranged through the local Public Assistance Committee or some charitable association (Red Cross, Regimental or Benevolent Fund, etc.).

2. CONVALESCENT TREATMENT.

In cases where the eye trouble is of a more serious nature, a long period of convalescence will enable a patient to return home better fitted to battle successsfully against disease. Experience has shown in this connection that if convalescence is to be of lasting value, the patient should, if possible, have a period of two or three months, with a minimum stay of six weeks. If the disease is of tubercular origin, sanatorium treatment under the State Tuberculosis Scheme may be arranged. In the case of children with this type of eye trouble, boarding out for several months at farms, or carefully selected private country houses has been effective in arresting and even apparently curing the disease.

There is, however, one great difficulty in arranging convalescence for patients with eye trouble. In cases of active ophthalmia requiring ophthalmic supervision, there is no Home open to adults and, with the exception of one small house for twelve children (the Mayfield Ophthalmic Convalescent Home, Sussex), there is, at present, only one institution that will accept children. This institution, run by the London County Council, is known as the White Oak Ophthalmic Schools, at Swanley, Kent. This Home combines the advantages of a hospital, convalescent home and school. Besides getting facilities for education, the children are in the charge of nurses, trained and skilled in the treatment of eye diseases. In addition, the Home is under the care of eminent ophthalmic surgeons. Children, boys and girls, from any part of the kingdom, suffering from active, chronic or contagious eye disease, are admitted up to the age of fourteen years, and remain there for periods varying from six months to several years, until the treatment is complete. The percentage of cures resulting is very high, and children who have been discharged seldom have a relapse.

3. INFANTILE OPHTHALMIA.

The London Council also maintains another very admirable institution known as St. Margaret's Hospital, Kentish Town. This is for acute cases of contagious eye disease contracted by babies at birth. This disease (ophthalmia neonatorum) unless treated, and treated immediately, leads to inevitable blindness. If taken in time, however, the child's sight can practically always be saved. At St. Margaret's facilities exist for the necessary hourly treatment, and in certain cases, the mother too may be treated. The less serious cases of this dangerous disease may be treated in the ordinary out-patient department of the eye hospitals, but this may necessitate visits twice daily for one to three weeks. The almoner must therefore be ready, if difficulties arise—as more often happens than not—to ensure the regular attendance of the child. While the mother is unfit to travel, the almoner must arrange an escort for the child ; or again, the question of raising the necessary fares is often a serious problem.

4. THE SCHOOL CHILD WITH DEFECTIVE VISION.

The London County Council School Clinics and Treatment Centres have their own specially trained social workers, through whom all necessary work for children suffering from minor defects in vision is provided. The hospital out-patient department deals with the more serious cases; take, for example, that of the child who is found to be suffering from progressive myopia. Here the question of the provision of suitable education arises, and the almoner has a great opportunity for working with the medical and educational authorities in ensuring that the child shall have the maximum amount of education with the minimum amount of eye-strain. In the Metropolitan area there are twenty schools for children with defective eyesight. Outside the London area there are, as yet, few local authorities who have been able to afford a special school for myopic children. The myopic child has had no choice between attendance at the ordinary elementary school or a school for blind children, neither of which alternatives meets his need. In such cases the almoner may overcome the difficulty by corresponding with the local educational authority or the headmaster of the school which the child in question attends. The master's co-operation in the hospital's work is sought, and detailed instructions as to the type of work suitable for the child to undertake are sent. In this way, though the education is unavoidably restricted, the disease, more often

than not, is arrested and the child's sight preserved. It may be appropriate, while discussing the problems of the school child with defective vision, to mention the new orthoptic out-patient clinics, recently inaugurated for treatment for squint. Regular and punctual attendance will be essential if the treatment, which is to consist of a series of educational exercises to strengthen the muscles of the eye, is to have successful results. The almoner, therefore, has a new field of work opening up before her in this connection.

5. IN-PATIENTS AND THEIR AFTER-CARE.

The every-day problems which meet the almoner in charge of the in-patient department of an eye hospital are, in many instances, similar to those encountered in a general hospital. Emergency admissions, with their attendant difficulties, the need for ensuring that there is adequate provision for young families left temporarily without a father or mother, the effort to maintain peace of mind for the patient—these are faced in every hospital ward. Take, for example, the case of a patient admitted to the ward of an eye hospital for a cataract operation. The operation necessitates three weeks in the wards, and if the patient is a wage-earner or the mother of a family arrangements must be made for the welfare of the home during this time. The operation over, the patient may need help in paying for spectacles. The powerful lenses required for cataract patients are expensive and often beyond their unaided means. It is the almoner's duty to see that the patient does not go away without the glasses owing to inability to pay for them, for the glasses ordered after such an operation are an important factor in establishing the final satisfactory result, and so enabling the patient, once blind, to see again.

One of the almoner's most difficult problems in eye work is the care of those patients whose sight after operation or treatment has been only partially restored. For the totally blind there are many organizations, both state and voluntary; but there exists no organization to help the partially blind, whose sight, not good enough to enable them to enter the open labour market, is not sufficiently defective for them to be registered as blind. These patients are therefore the special care of the almoner, who will need all her qualities of resourcefulness, patience and ingenuity, if her efforts to help are to be successful. Even then, experience has shown that both she and the patient may be doomed to disappointment.

B.—Care of the Blind.

While, in many instances, operation or treatment results in the restoration of sight, the almoner has always much work to do for those for whom treatment is of no avail, or for those who, through accident or injury, can never hope to regain their sight. The knowledge of permanent blindness or even the loss of all useful vision comes to some temperaments as a sudden shock, while to others the full realization dawns slowly after weeks or even months. In whichever way the patient is affected, he will need all the courage he can muster to face and overcome the appalling calamity of blindness. It is here that the almoner can again help the patient by sympathy, by leading him to the mental readjustment necessary in his new estate, and by devising plans for future training, work, or maintenance of the home.

Welfare work for the blind, in common with other social services, sprang from voluntary or individual philanthropic effort. During the last hundred years, as the importance of movements for social service have become recognized, the state, realizing its responsibility, has stepped in and taken over either partial or complete charge. By the passing of the Blind Person's Act in 1920, the state has definitely assumed responsibility for the care of the blind. The Government and the local Public Authorities, however, work in close co-operation with the Voluntary Blind Societies. These societies, although they receive grants-in-aid from the central exchequer, depend largely on voluntary subscriptions. It is according to the measure of their activity, that local authorities have been impressed by the need for the development of Blind Social Service. These authorities vote money for Blind Schools for children up to 16 years; Blind Workshops for persons from 16 to 40 years of age; Home Teachers for Braille, Moon and Handicrafts; Blind Wireless Sets; Home Visitors; Blind Homes; Blind Allowances to supplement the Government Blind Pension of 10s. a week for persons from 50 to 70 years of age; or allowances for maintenance during training. The Blind Societies, as agents for these authorities, administer the grants. The Blind Associations, the value of whose work cannot be overestimated, have visitors even in the most remote parts of the United Kingdom and keep in touch with both young and old, giving advice and help in every way possible.

In addition to State and Local Authority Welfare Schemes, there are special Blind Societies, such as Gardner's Trust for the Blind, Fuller's Charity, St. Dunstan's for ex-Service Men,

and many others to whom application may be made in individual cases.

As will be realized from the foregoing, the almoner's share in the care of the blind has become much simplified. In one way or another provision is made to meet the most pressing needs of the blind in all stages of life from the cradle to the grave. The almoner's important duty therefore lies first in acquiring a complete and up-to-date knowledge of all avenues of help, secondly in having the ability to understand the individual's particular and often complicated needs, and then in being able to direct him (or her) to a wise choice which will fulfil those needs.

The growing importance of the state in the administration of Public Health and Social Service has been stressed to show how important it is that the almoner should keep abreast of the march of events. To illustrate the effect of government legislation on the work of an eye hospital, one may point to the adoption, in recent years, of the Ophthalmic Benefit Scheme by the Approved Societies. Under the National Health Insurance Scheme, certain of the Approved Societies include Ophthalmic Benefit amongst their Additional Benefits. This benefit entitles a member to have his eyes examined by a consulting surgeon or a qualified optician privately for a fee which the Society pays. As a result of this scheme, many ophthalmic surgeons, realizing that the state has accepted financial responsibility for such examinations, no longer see patients entitled to Ophthalmic Benefit at hospitals; the hospitals have therefore had to readjust their administration. The almoner as intermediary between the hospital and the surgeon on the one hand, and the state and the patient on the other, is in many cases the agent through whom the readjustment is effected.

CHAPTER V.

A DAY IN AN ALMONER'S OFFICE.

"'Come, tell me how you live,' I said, 'and what it is you do.'"

IT has been suggested that our old friend the White Knight must have been a trained almoner. If so, surely his training was somewhat superficial. You will note his inquiry was restricted to the present tense, but the past tense should have been used in order to obtain a background for the old man's present troubles, and certainly the future tense should have come into play if those troubles were to be successfully removed.

The duties of an almoner differ, to a certain degree, in every hospital. The following is a brief attempt to describe a day's work in a small general hospital where there is only one almoner. Possibly each day is superficially the same as any other, and a certain amount of routine has to be pursued, yet no almoner could ever say she has known two days alike; the unexpected is always apt to occur. Amongst the large number of patients interviewed, no two human beings are alike in background, character or outlook, nor are their problems ever identical.

No matter how early the almoner arrives, she is bound to find a collection of all sorts and conditions of people outside her door. The mothers have perhaps been up and about since 6 o'clock and done their housework, washed and sent several children off to school, taken the baby to a neighbour to look after while they are at hospital, and put on the dinner to cook so that there is something ready for the family at midday. One child perhaps had to be left in bed as she had a cold and was feverish. They arrive naturally hurried and worried, and when they fetch their Letters from the almoner's room want to explain their difficulties and to ask advice about some personal anxiety. The almoner, on her side, wishes to find out whether the District Nurse did call as arranged and do the dressing for the child attending hospital; whether the father had a full-time week; whether the mother has been able to prevent the rheumatic child from sitting out on the stone doorstep in damp clothes; and often encouragement and a few common-

sense hints will give her fresh courage to try again to systematize the supervision of the child. The child is then taken to the doctor, and often he orders some new treatment, to carry out which will involve expenditure, time and intelligence. The mother will perhaps come back to the almoner with a story of how impossible it is for her to pay for an instrument, or that she cannot keep the child in bed as she has to go out for so many hours a day to augment the family income. The tangle has to be straightened out, help arranged for financing the cost of the instrument, after inquiry. Perhaps the visitor of the Invalid Children's Aid Association is asked to act as the family watcher and friend and the liaison between the hospital and the home.

The adult patients come in one by one to fetch their medical notes. The almoner collects donations from some and thanks each individual for helping the hospital; greets old friends and asks about any special difficulties of which she happens to know in the family. One patient thought last week he was going to get a job; has he been successful? Another promised to bring a Hospital Saturday Fund letter. Has he been able to obtain it? One went away the week before, after her first visit to hospital, without coming in to see the almoner. This must be remedied.

During the first pause, the day's letters are opened and read through quickly to see if there is anything requiring immediate attention. One is from the Invalid Children's Aid Association asking for a report on the health of a child who is coming to hospital that morning. A note must be made out to go into the doctor with the patient telling of this request. Letters come from patients asking on what day they should next attend hospital, often not mentioning the name of the doctor they saw or the department in which they saw him! The secretary of one branch of a charitable society writes to say that her committee have agreed to co-operate with the Samaritan Fund of the Hospital in sending away a patient for convalescence; that of another branch of the same society writes that her Committee have decided that they cannot help a man to obtain a special surgical boot; they have known of him for several years, the references that he has given them have always been unsatisfactory, they think he should apply to the Public Assistance Committee for the boot. There is a letter from a Borough Medical Officer enclosing reports of a a patient who has just been discharged from a sanatorium where he appears to have made very good progress; and one from the County Council in answer to an application for prolonged institutional treatment for a child with rheumatism.

Two ex-in-patients send donations, and a third writes to explain why he finds it impossible to do so at present.

Meanwhile the business of giving out Medical Letters to the out-patients must continue. Some patients require notes before seeing the doctor; one patient has returned from a Convalescent Home, is she fit to go back to her work? Another has to have an application form filled in; some patients have to get instruments that are waiting in the office for approval by the surgeon. Almost all these, as well as all the new patients, will return after seeing the doctor for a further interview, and notes to the school teacher, to employers, to instrument makers, to Approved Societies and Charities will have to be written.

The day's post is then given more careful consideration. If the almoner has a clerk, letters are dictated and a strenuous and much interrupted hour is passed, though usually few new patients appear for about an hour after the doctor begins. This does not mean freedom to concentrate. Seven interruptions during one letter are quite normal, The clerk must keep her head and wait, but doctors, matron, ward sisters, even medical students naturally cannot do so. For all the almoner must have a welcome and not a worried look. She must be able to switch her mind back and forth, and answer questions about the patients from her memory if possible, without having to look up every case.

Letters dictated, the new patients coming from the doctor must be interviewed. A patient who has recently undergone an operation for Graves' disease comes in. On her notes her doctor has written, "Will the almoner please see this patient? It is important that she should rest and avoid all unnecessary worry." The almoner knows already that she has a husband who is out of work and three young children. She has, however, a mother and married sister living not very far away. The almoner decides to obtain the patient's consent that she should discuss plans with one of these relatives and meditates asking a charitable society if they would help this woman to employ someone to take her children out every afternoon to enable her to rest.

Mary M., aged 19, has been sent by her own doctor to see the mental specialist. She was recently a patient in a large County Council Hospital. She was transferred there for a tubercular knee. She gradually became miserable at the sanatorium and felt terrified in the large wards. She disliked bright lights and refused to go out on the balcony and, finally, she discharged herself. Her knee condition is fortunately satisfactory, but the doctor decides she needs a special

convalescence. Great care must be taken that none of the conditions of the hospital or sanatorium are repeated. She will go to a small country home where she will be supervised by the Mental After-Care Association.

Here is a man whose address conveys nothing to the uninitiated. He has a contagious skin infection requiring dressing preceded by hot bathing six times a day. But the almoner knows the address is a night shelter for homeless men; she must persuade him to seek admission to a Municipal Hospital for a few days, for his own sake and that of others.

Nellie B., aged 4, has just come with her sister, aged 12. Nellie has come because "her nerves is at her." The doctor discovered acute constipation; the almoner discovered "how she lived." She gets up between 9.30 and 10 a.m., she goes to bed between 10 and 10.30 p.m. She has no appetite, that is to say she eats nothing at meal-times, but her mother has discovered that the most effective way of silencing her between meals is to give her a piece of bread and margarine whenever she asks for it. A request is sent that the mother shall herself accompany Nellie on her next attendance and if it is not complied with the almoner will ask a visitor to go and see her at home.

Mrs. M. is a young married woman who has been recommended for admission by the surgeon in order to have an operation. She has a husband and three children under 10. Mr. M. is out at work all day and Mrs. M. does not know of anyone who can look after the children. After some discussion she thinks of a sister-in-law who might step in. She is encouraged to make further efforts to arrange things herself, but, at the same time, it is impressed upon her that if she really cannot find anyone to look after the children, she must come and tell the almoner, who will make arrangements for them to go into a home. She must on no account wait till the last minute before thinking what is to happen to the children. To leave nothing to chance, a home visitor is asked to call in a few days.

A child of a year old is the next patient to come in. He has acute bronchitis; his mother has been told to take him home quickly and put him to bed. A District Nurse is rung up and asked to keep her eye upon him for the next few days.

A clergyman calls to find out what can be done for an old parishioner of his who has been a patient at the hospital for many years and is now too old and feeble to live alone. Various alternatives are discussed; she must be brought to see her doctor as soon as possible and future plans will be based on the result of a medical examination.

In the afternoon time is spent considering the needs of some of the in-patients. One woman must leave the hospital; her doctor considers that she has not long to live and will require too much nursing to be looked after at home. The almoner decides to see her husband and explain to him the advantages of a Home for Advanced Cases. Two patients have been recommended for convalescence. Which home would suit them best? Where would they like to go? Will their Approved Societies contribute towards the expense? If not, how is the cost to be met? Before all these questions can be answered, the almoner will have to go up to the wards to see the patients and leave with the sister of the ward suitable medical certificates to be completed by the doctor.

Several patients have been recommended for instruments of one kind or another; one, an abdominal belt, one a spinal jacket, and a third a caliper splint. The almoner must make up her mind how all these are to be paid for and must order them promptly from the appropriate instrument maker, as no delay is admissible when the patient will, in all probability, be ready for discharge as soon as the appliance is forthcoming, and is occupying a bed sorely needed for another patient.

A patient comes in later, by appointment, to show his National Health Insurance contribution card so that the almoner may discover what hitch is preventing him from drawing his sickness benefit.

The relatives of a man who fell off a ladder in a neighbouring street the day before, and was admitted as an emergency, come in. They tell the almoner about his home and his work. It will clearly be impossible for him to make any contribution towards the cost of his maintenance while in hospital: on the other hand, his wife and three children will be able to manage while he is away since, as his accident happened at work, he will be entitled to about 30/- a week compensation, and the eldest boy is earning 18/-.

The principal work of the day seems drawing to a close when a tap at the door is heard. It is a patient about whom the doctor had appealed to the almoner the day before, a young girl who is expecting a baby in three months time, who at the first interview seemed sullen and unwilling to make any confidences. She has come in at the end of her day's work, rather desperate and terrified of what the future holds. She feels that the hospital is a sanctuary where any confidence will be regarded as sacred. There can be no consideration of time spent at this juncture as the almoner slowly feels her way in the task of disentangling the girl's story with a view to helping her to face the difficult months ahead.

In addition to all that has been described, the almoner will probably have some piece of routine work allotted to each day. On Monday perhaps she will go through all her current cases, making certain that she has not overlooked anything that she has planned to do. On Tuesday she will put away the cases on which she has, at any rate temporarily, completed her work, entering the results of each case in a register. One day she must bring up to date the account for patient's instruments and convalescent treatment, which are all recorded in detail in two special books. On another day she will probably find it advisable to go over the accounts of her Samaritan Fund. Either weekly or monthly it will be necessary to consider the question of statistics.

Truly, each day brings its own special problems, its successes and its failures, its own share of routine duties, its own share of statistical work. But each morning the almoner starts out, as it were, into unknown paths of adventure in the difficult task of case work. Every day is full of interest, but there must be some which end with the feeling uppermost in the almoner's mind—

"This oughtest thou to have done and not to have left the other undone."

ADDENDA.

A.—State Aid for Certain Special Work in Voluntary Hospitals.

In recent years local authorities have been empowered to make grants from public funds to the voluntary hospitals for the treatment of certain diseases, i.e., the social diseases—venereal disease and tuberculosis—and for maternity work. A certain proportion of these grants comes from national taxation, but is not administered directly by the Ministry of Health. Instead, block grants are made by the Ministry to the local authorities who in turn apportion this money, with the addition of grants from the local rates, to the voluntary hospitals. In general there is only one local authority, the county or county borough council (a county borough must contain at least 50,000 inhabitants); but in London the scheme of local government is more complicated and, while the grant for the treatment of venereal disease is apportioned by the London County Council in the manner already described, the grants for tuberculosis and for maternity and child welfare are apportioned by the Councils of the local boroughs into which the County of London is divided. The grant for the treatment of tuberculosis is only given where the voluntary hospital maintains within its buildings a dispensary for out-patients which forms an integral part of the borough scheme for the treatment of tuberculosis. For example, in the Brompton Hospital, there is a Tuberculosis Dispensary for the Borough of Chelsea, and in St. Thomas's Hospital there is one for the Borough of Lambeth. No grant is made for the treatment of tuberculosis in the ordinary out-patient department of the hospital.

In like manner, the Borough Councils make grants towards the maintenance of ante-natal and infant welfare clinics in the voluntary general and maternity hospitals.

In addition to these grants, the voluntary hospitals with medical school receive a *per capita* grant from the Board of Education for each student, while the local University makes general grants for teaching purposes. In the case of London University, a grant is made to each of the twelve medical schools in the London area.

The work of King Edward's Hospital Fund for London has

already been described. The hospitals in the capital also receive annual grants from the Hospital Sunday Fund which is derived from the proceeds of the collection made in the churches of all denominations on a certain Sunday of the year, known as "Hospital Sunday," and from the Hospital Saturday Fund which will be described later under the heading of Contributory Schemes.

B.—Contributory Schemes.

In order to help the voluntary hospitals various types of workmen's contributory schemes have been started all over the country. These schemes all depend on a weekly contribution of a few pence made by the working man and generally cover himself, wife, and all children under sixteen years of age, but some of them are run by a hospital for its own benefit, some by the group of hospitals in one town, cf. the Sheffield "Penny in the Pound" scheme, and some by a large firm for the benefit of one or more local hospitals.

In London there are two schemes, both covering the whole Metropolis, both run independently of the hospitals, and to which the hospitals belong or not, as their governing bodies see fit. These are the Hospital Saving Association and the Hospital Saturday Fund. Membership of either of these schemes entitles any of the family to free out-patient and in-patient treatment in any of the co-operating hospitals provided that he or she is suitable medically. Membership of the Hospital Saving Association is open to any individual coming within certain income limits and paying the weekly contribution of threepence. The Hospital Saturday Fund, which is far older than any of the other schemes, is so called because it consists of the contributions made by workmen on their weekly pay day to some employee of their firm appointed as a collector. Both organizations make annual grants to all voluntary hospitals co-operating in their scheme.

C.—Approved Societies.

Approved Societies are the bodies through which the National Health Insurance Act of 1911 is administered and are organizations of insured persons brought into being with the express object of administering that Act. They must be "approved" by the Minister of Health and, for this purpose, they must satisfy the conditions that they shall not be carried on for profit, that they must be under the absolute control of their insured members, or their duly elected

representatives, that they must comply with all regulations issued by the Minister of Health and must submit their accounts for audit by Treasury Auditors.

The statutory benefits established under the Act do not give any direct help to voluntary hospitals, but it is provided that quinquennially the assets and liabilities of every Approved Society shall be actuarially valued and, if there be a surplus, such surplus may be used for granting "additional" benefits to insured persons. The assets of the various Societies are valued separately with the result that the amount available for "additional" benefits varies considerably from Society to Society. Also the different Societies are at liberty to choose from a considerable list which, if any, "additional" benefits they will provide.

Only two of the "additional" benefits available provide direct help to the voluntary hospitals, namely Hospital Benefit, which is the payment to the hospital of the whole or part cost of the maintenance of the insured person while an in-patient, and Dental Benefit, which covers the whole or part cost of dental treatment as well as of dentures; but there are other "additional" benefits which help the insured person to obtain such necessary accessories to hospital treatment as convalescent home treatment, surgical appliances and spectacles.

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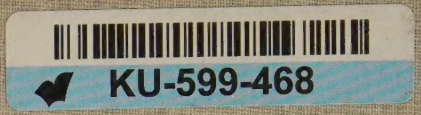
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